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## RESOLVING THE JUDICIAL PARADOX OF "EQUITABLE" RELIEF UNDER ERISA SECTION 502(A)(3)

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# RESOLVING THE JUDICIAL PARADOX OF “EQUITABLE” RELIEF UNDER ERISA SECTION 502(A)(3)

COLLEEN E. MEDILL\*

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\* Professor of Law, University of Nebraska College of Law. My work on this Article began when I was a faculty member at the University of Tennessee College of Law. The research for the Article was supported by summer research grants from the University of Tennessee College of Law for 2000–2003, and from the University of Nebraska College of Law for 2004–2005. I would like to thank my Nebraska faculty colleagues, Richard Moberly and Steve Willborn, for reviewing the entire manuscript of this Article at the prepublication stage and providing helpful comments. I also would like to thank Joan Heminway and Susan Stabile for responding to my questions concerning federal securities laws, and John Langbein for responding to my questions concerning the Seventh Amendment right to jury trial and the historical evolution of the early common law of trusts. All errors and omissions remain my own.

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## I. INTRODUCTION

In *Paradoxes of the Regulatory State*, Professor Cass R. Sunstein identified the phenomenon of a regulatory paradox.<sup>1</sup> An analogous “judicial paradox”<sup>2</sup> exists today concerning the state of equitable remedies available under the Employee Retirement Income Security Act of 1974<sup>3</sup> (“ERISA”). This paradox exists not as a result of implementation of the statute by a federal regulatory agency, but rather as the result of numerous Supreme Court decisions interpreting the meaning of “appropriate equitable relief” for claims brought under Section 502(a)(3)<sup>4</sup> of ERISA.<sup>5</sup>

When Congress enacted ERISA in 1974, the federal courts were directed to develop a federal common law of ERISA remedies.<sup>6</sup> Over thirty years later, the body of federal common law concerning the equitable remedies available under Section 502(a)(3) forms a virtual legal labyrinth.<sup>7</sup> Plan participants who

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1. Cass R. Sunstein, *Paradoxes of the Regulatory State*, 57 U. CHI. L. REV. 407 (1990).

2. See Judith Resnick, *Trial as Error, Jurisdiction as Injury: Transforming the Meaning of Article III*, 113 HARV. L. REV. 924 (2000), for an analysis of how the institutions of the federal judiciary have developed administrative agency-like attributes and characteristics.

3. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended in scattered sections of 26 & 29 U.S.C.) (“ERISA”).

4. 29 U.S.C. § 1132(a) (2000) (“Section 502(a)”).

5. In order of decision, these Supreme Court precedents are: *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134 (1985); *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993); *Varity Corp. v. Howe*, 516 U.S. 489 (1996); *Harris Trust and Savings Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238 (2000); *Great-West Life & Annuity Insurance Co. v. Knudson*, 534 U.S. 204 (2002); and *Sereboff v. Mid Atlantic Medical Services, Inc.*, 126 S. Ct. 1869 (2006).

6. See *Varity*, 516 U.S. at 497 (noting that in interpreting ERISA, federal courts will have to look beyond common law trust principles, taking into account the language, structure, and congressional purposes of the statute); *Mertens*, 508 U.S. at 264–65 (White, J., dissenting) (stating that courts must work from the common law of trusts in construing the scope of appropriate equitable relief for Section 502(a)(3)); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989) (“[C]ourts are to develop a ‘federal common law of rights and obligations under ERISA-regulated plans.’” (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987))); *Russell*, 473 U.S. at 155–57 (Brennan, J., concurring) (noting that Congress authorized the federal courts to fine-tune ERISA’s remedial scheme by developing federal common law to fashion appropriate equitable relief under Section 502(a)(3)); *Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 24 n.26 (1983) (“[A] body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans.” (quoting 129 CONG. REC. 29942 (1974) (remarks of Sen. Javits))).

7. See *Great-West X, Crosby v. Bowater: The 6th Circuit Says Claim for Violation of ERISA Doesn’t Seek Equitable Relief*, ERISA LIT. REP. (Glasser Legal Works), Oct. 2004, at 11, 14 (“For a never-ending stream of surprises on significant points. . . nothing compares to the current ferment. . . [These cases]

enter this labyrinth find that, contrary to their expectations, federal law does not protect their rights concerning plan benefits.<sup>8</sup> At the same time, employers who sponsor benefit plans for their employees find that the complexities of ERISA litigation can substantially increase the costs of plan administration and the enforcement of plan terms during a time when employer-sponsored benefits, particularly health care benefits, are increasingly unaffordable.<sup>9</sup>

Employers and plan participants are not the only parties unhappy with the current state of ERISA remedies jurisprudence. The level of frustration among the lower federal judiciary has steadily escalated to the point where federal judges now use their written opinions to call for Congressional reform of what is perceived as an unjust remedies scheme.<sup>10</sup> Unfortunately, action by Congress has not been, and is not likely to be, forthcoming.<sup>11</sup>

This state of affairs has been the subject of a growing body of scholarly critique.<sup>12</sup> Most recently, the theoretical foundation for the Supreme Court's interpretation of Section 502(a)(3) – the historical distinctions between remedies available at law and in equity (the “law-equity paradigm”) – has drawn a sharp public rebuke by Professor John H. Langbein of Yale Law School. Professor Langbein has traced the root of the problem to fundamental errors made by the Supreme Court in a series of opinions construing the meaning of “equitable” relief under Section 502(a)(3).<sup>13</sup> Professor Langbein proposes that the remedy of make-whole relief available under the common law of trusts should be available as “equitable relief” under Section 502(a)(3).<sup>14</sup>

The prospect of make-whole relief under Section 502(a)(3) raises several questions. First, what does the universe of breach of fiduciary duties claims, which are most closely associated with make-whole relief under the common law of trusts, look like? Second, what doctrinal theory should guide the federal courts in determining the types of “equitable relief” available for *other* types of claims brought under Section 502(a)(3) that do not involve an alleged breach of fiduciary duty?

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can only hasten the day – which can't come soon enough for us – when the Supreme Court takes another stab at straightening out the meaning of equitable relief.”).

8. See discussion *infra* Parts II.A.1–4.

9. See discussion *infra* Part II.A.5.

10. See discussion *infra* Part II.A.6.

11. See discussion *infra* Part II.A.6.

12. See discussion *infra* Part II.C.

13. See generally John H. Langbein, *What ERISA Means by “Equitable”*: *The Supreme Court's Trail of Error in Russell, Mertens, and Great-West*, 103 COLUM. L. REV. 1317 (2003).

14. See discussion *infra* Part II.B.

It is the variety of possible claims that makes interpretation of Section 502(a)(3) so challenging for the federal judiciary. As a governing theory, the common law of trusts becomes less compelling for the interpretation of Section 502(a)(3) in the context of claims that are not closely related to the trustee-based roots of ERISA. Section 502(a)(3) also encompasses claims that are not fiduciary in nature, such as claims against plan participants, claims against nonfiduciary plan service providers, and claims against third parties. Determining the remedies available under Section 502(a)(3) for these nonfiduciary claims is a difficult judicial task.

This Article attempts to explore and illuminate the current theoretical void. The Article develops a statutory and policy-based theory that reconciles Professor Langbein's analysis of equitable relief in the context of fiduciary claims with the other types of claims, also authorized by Section 502(a)(3), that are not strongly rooted in the common law of trusts and trustees. In the course of developing this statutory and policy-based theory, the Article makes the following claims:

1. The Supreme Court has been laboring under the misperception that the universe of defendants and related claims under Section 502(a)(3) is unlimited and presents a judicial slippery slope.<sup>15</sup> Based on this false premise, the Supreme Court has miscalculated the potential risk of "slippage" and overreacted by embracing the law-equity paradigm, resulting in a rigid rule that only remedies "typically"<sup>16</sup> available in a court of equity are available under Section 502(a)(3).

2. It is possible to deduce *all* of the possible categories of defendants and related claims that make up the universe of private civil actions that may be brought under Section 502(a)(3). These categories of defendants and related claims can be logically deduced from ERISA's complex statutory scheme using a three-stage modeling analysis. The results of this modeling exercise, which takes as its inspiration the modeling exercise technique made famous by Guido Calabresi and A. Douglas Melamed,<sup>17</sup> are summarized in Part III of the Article and presented in detail in Appendices A, B, and C.

3. Based on the results of the modeling exercise, there are six possible categories of defendants and related claims under Section 502(a)(3). These six categories are:

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15. See discussion *infra* Part II.C.

16. See discussion *infra* Part II.B.; see also *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 210 (2002) (quoting *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256 (1993)).

17. Guido Calabresi & A. Douglas Melamed, *Property Rules, Liability Rules and Inalienability: One View of the Cathedral*, 85 HARV. L. REV. 1089 (1972).

Category I:	Violation of Plan Design Requirements
Category II:	Retaliation, Improper Plan Amendment Procedure, or Inurement of Plan Assets
Category III:	Breach of Fiduciary Responsibilities (Including Wrongfully Denied Claims for Plan Benefits)
Category IV:	Violation of Plan Terms by Participants
Category V:	Knowing Participation in Breach of Fiduciary Duties or Prohibited Transactions by Non-Fiduciary Parties in Interest
Category VI:	Claims Against Third Parties

These six distinct categories of defendants and related claims refute the characterization of Section 502(a)(3) as a potential judicial slippery slope.

4. Once Section 502 (a)(3) is conceptualized as authorizing six distinct categories of defendants and related claims, it becomes possible for federal judges to use the underlying policy objectives that are unique to each category as the basis for discerning what types of equitable relief are “appropriate” under Section 502(a)(3). The essence of my proposed theory is captured by the *ERISA Policy Triangle*. Using the ERISA Policy Triangle, the federal courts can achieve uniformity of interpretation by standardizing the remedies available *within* each particular category, while at the same time satisfying the need for flexibility by recognizing that what are “appropriate” equitable remedies may differ *across* categories. Different categories of defendants and related claims raise different policy concerns, and therefore may warrant a more narrow or a more expansive view of “appropriate” equitable relief available under Section 502(a)(3).

5. The Supreme Court’s major prior precedents interpreting Section 502(a)(3), when stripped of superfluous dicta, can be read as consistent with the Article’s proposed approach to statutory interpretation. Therefore, the doctrine of *stare decisis* does not present an obstacle to adopting a fresh judicial approach to interpretation of Section 502 (a)(3).

The kernel of the Article’s thesis is not novel. Since the Supreme Court first interpreted the meaning of “equitable” relief in *Mertens v. Hewitt Associates*,<sup>18</sup> the Department of Labor has urged the federal courts to consider the status of the defendant and the nature of the claim in determining the remedies available under Section 502(a)(3).<sup>19</sup> What has been lacking to date in the scholarly literature is a rigorous and comprehensive analysis of

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18. *Mertens*, 508 U.S. 248.

19. See discussion *infra* Part II.C.3.

*why* the Department of Labor's position is theoretically sound *as a matter of statutory construction*. This Article presents the theoretical case for the Department of Labor's long-standing litigation position. The Article demonstrates that a statutory and policy-based theory is the superior approach to judicial interpretation of Section 502(a)(3).

A cautionary word is appropriate before the reader proceeds to the body of the Article. To reduce the length of the Article, I have assumed that the reader has an intermediate level of familiarity with ERISA's statutory provisions and the Supreme Court's major precedents in the area.<sup>20</sup> These precedents are discussed in the Article without providing background information to the reader. Novices to ERISA are strongly encouraged to read the original Supreme Court cases in conjunction with Professor Langbein's article,<sup>21</sup> which provides a detailed analysis of the major Supreme Court precedents of *Massachusetts Mutual Life Insurance Co. v. Russell*, *Mertens v. Hewitt Associates*, and *Great-West Life & Annuity Insurance Co. v. Knudson*. ERISA experts who are interested solely in my conclusions should proceed immediately to Part III.C of the Article and begin reading at that point.

## II. THE JUDICIAL PARADOX OF EQUITABLE REMEDIES UNDER ERISA

### A. *Illustrations of the Judicial Paradox*

Over thirty years ago, Congress determined that federal law exclusively should regulate employee benefit plans. Since the enactment of ERISA in 1974,<sup>22</sup> these plans and the benefits they provide to employees have become increasingly important fixtures in the modern workplace. During this period, the designs, features, and types of benefits provided by employer-sponsored plans have evolved in response to broad societal, demographic and economic trends. Retirement plans have moved increasingly from a paternalistic, employer-managed system to one where the plan's participants are primarily responsible for funding and managing their own retirement assets.<sup>23</sup> In the health care area, employers

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20. See precedents listed *supra* note 5.

21. Langbein, *supra* note 13.

22. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended in scattered sections of 26 & 29 U.S.C.).

23. See generally Edward A. Zelinsky, *The Defined Contribution Paradigm*, 114 YALE L.J. 451 (2004) (discussing the rise of the defined contribution plan); Colleen E. Medill, *The Individual Responsibility Model of Retirement Plans Today: Conforming ERISA Policy to Reality*, 49 EMORY L. J. 1, 4-13 (2000) (discussing the individual responsibility model).



have responded to rising costs by replacing the traditional insured health care plan, first with employer “self-insured” health care plans,<sup>24</sup> and later with managed care plans.<sup>25</sup> These trends have caused the roles and responsibilities of persons associated with employee benefit plans – the sponsoring employer, the plan’s participants, and the other parties who assist in managing and administering employee benefit plans – to change dramatically. Yet ERISA’s core statutory provisions that regulate the conduct of persons associated with employee benefit plans and provide a remedy for violations have remained remarkably consistent since their enactment in 1974.<sup>26</sup> As a result, the federal courts increasingly have struggled to apply ERISA’s original statutory language to situations arising in today’s modern workplace.

Many of these modern ERISA claims are brought under Section 502(a)(3) of ERISA<sup>27</sup> (“Section 502(a)(3)”), a key provision that authorizes private civil actions. Section 502(a)(3) authorizes a plan participant, beneficiary, or fiduciary to bring a claim in federal court to obtain injunctive or “other appropriate equitable relief” to remedy any violation of title I of ERISA, or to enforce the terms of an employee benefit plan.<sup>28</sup> On its face, the statutory language of Section 502(a)(3) appears to offer a flexible mechanism by which the federal courts may address issues concerning employee benefit plans that Congress did not anticipate in 1974. The very nature of Section 502(a)(3) as a flexible “catchall remedial provision,”<sup>29</sup> however, has proven problematic. First in *Mertens v. Hewitt Associates*,<sup>30</sup> again in *Great-West Life & Annuity*

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24. See Colleen E. Medill, *HIPAA and Its Related Legislation: A New Role for ERISA in the Regulation of Private Health Care Plans?*, 65 TENN. L. REV. 485, 491–93 (1998) (explaining the differences between insured and employer self-insured health care plans and the financial incentive for employers to self-insure their health care plans).

25. See *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 369–70 (2002) (discussing the increase in managed care plans as the dominant form of health plan coverage); *Pegram v. Herdrich*, 530 U.S. 211 (2000) (discussing the fiduciary implications of managed care plans).

26. See 29 U.S.C. § 1104(a) (2000) (fiduciary duties); 29 U.S.C. § 1105 (2000) (co-fiduciary duties); 29 U.S.C. § 1106(a)-(b) (2000) (prohibited transactions); 29 U.S.C. § 1109(a) (2000) (liability for breach of fiduciary duty); 29 U.S.C. § 1132(a) (2000) (civil actions and remedies).

27. 29 U.S.C. § 1132(a)(3) (“Section 502(a)(3)”).

28. The complete text of Section 502(a)(3) reads:

A civil action may be brought — by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

29 U.S.C. § 1132(a)(3).

29. *Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996) (Thomas, J. dissenting).

30. 508 U.S. 248 (1993).

*Insurance Co. v. Knudson*,<sup>31</sup> and most recently in *Sereboff v. Mid Atlantic Medical Services, Inc.*,<sup>32</sup> the Supreme Court has defined the nature of equitable relief available under Section 502(a)(3) not as a flexible remedial mechanism, but rather by reference to the historical distinctions between remedies available at law and remedies available in equity (the “law-equity paradigm”).<sup>33</sup> Under the law-equity paradigm, equitable remedies under Section 502(a)(3) include injunction, mandamus, restitution, and enforcement of an equitable lien or a constructive trust, but exclude compensatory damages.<sup>34</sup>

It is the combination of Section 502(a)(3) as the catchall claim of last resort for private litigants under ERISA, coupled with the Supreme Court’s interpretation of equitable relief based on the law-equity paradigm, that has led to the judicial paradox of Section 502(a)(3). The crux of the paradox lies in the application of the Supreme Court’s law-equity paradigm by the lower federal courts to situations that are far different from the circumstances of *Mertens* and *Great-West*.<sup>35</sup> The cases described below illustrate how the judicially created paradox of “equitable” relief under Section 502(a)(3) operates in a variety of contexts.

### 1. *Illegal Plan Terms*

Congress intended ERISA to regulate strictly the methods by which a participant’s benefits in a retirement plan are accrued and become vested.<sup>36</sup> In *Crosby v. Bowater Inc. Retirement Plan*,<sup>37</sup> a class of plan participants alleged that their employer’s retirement plan used a method to calculate the lump sum value of their retirement benefits that violated the statutory vesting rules of ERISA Section 203(a).<sup>38</sup> The district court agreed that the plan’s

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31. 534 U.S. 204 (2002).

32. 126 S.Ct. 1869 (2006).

33. See Langbein, *supra* note 13, at 1350.

34. See *Sereboff*, 126 S.Ct. at 1874-75 (permitting enforcement of an equitable lien based on a pre-existing agreement); *Great-West*, 534 U.S. at 210–11, 216–17 (discussing remedies typically available in equity); *Mertens*, 508 U.S. at 256 (recognizing that “equitable relief” refers to categories of relief available in equity).

35. *Great-West Life IX: Millsap, Qualchoice, and Skretvedt*, ERISA LIT. REP. (Glasser Legal Works), Aug. 2004, at 13.

Call us in a rut, but neither we nor the circuit courts are able to stay away from [*Great-West*]. As the decisions discussed in this article show, the question of what counts as “equitable relief” that can be awarded on a claim brought under ERISA §502(a)(3) just keeps coming to the surface in a wide variety of cases.

*Id.*

36. See 29 U.S.C. §§ 1053–1054 (2000) (listing the requirements for the accrual of benefits).

37. 382 F.3d 587 (6th Cir. 2004).

38. 29 U.S.C. § 1053(a).

method of calculation was illegal and granted summary judgment to the plaintiffs, ordering the plan to recalculate the lump sum benefit amounts due the plaintiffs and to refund immediately the amount of any underpayments with interest. On appeal, the Sixth Circuit dismissed the plaintiffs' claim because the remedy ordered by the district court – a payment of money – was not “equitable” under Section 502(a)(3).<sup>39</sup> The plaintiffs were left without any recourse, despite the fact that the plan used a method that was illegal under ERISA to calculate the lump sum value of their retirement benefits, and the plan paid the plaintiffs a lesser amount than they were entitled to receive under the statutory vesting rules of ERISA.

## 2. Retaliatory Conduct by Employers

Congress intended ERISA to protect the rights of plan participants by prohibiting retaliatory actions that adversely impact the terms or conditions of the participant's employment, with the termination of employment being the most severe type of retaliation.<sup>40</sup> This statutory prohibition is found in ERISA Section 510 of ERISA (“Section 510”).<sup>41</sup> Section 502(a)(3) serves as the claim and remedy provision for a Section 510 violation.<sup>42</sup>

Prior to the Supreme Court's decision in *Great-West*, the lower federal courts awarded back-pay, and sometimes awarded front-pay, as equitable relief under Section 502(a)(3) if the employer illegally retaliated against a plan participant in violation of Section 510 by terminating the participant's employment.<sup>43</sup> After *Great-West*, backpay and frontpay may no longer be available as

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39. *Crosby*, 382 F.3d at 594. The court in *Crosby* noted:

But what if the benefits are not claimed to be due under terms of the plan, strictly speaking, but under the terms of a statute — in this case ERISA §203(a), — setting forth requirements that the plan must satisfy? The answer, we believe, depends on whether the claim for benefits allegedly due under the statutory requirements is or is not, at bottom, a claim for injunctive or other equitable relief. No matter how well founded it may be as a matter of substantive law, a claim for benefits is not cognizable under §502(a)(3) of ERISA unless it is a claim for “equitable relief.”

*Id.* (citation omitted).

40. See 29 U.S.C. § 1140 (2000).

41. § 1140.

42. See *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142–44 (1990) (stating that Congress intended Section 502(a)(3) to be the exclusive remedial provision for ERISA violations, including Section 510 violations).

43. See *Schwartz v. Gregori*, 45 F.3d 1017, 1022–23 (6th Cir. 1995) (awarding both back-pay and front-pay); *Warner v. Buck Creek Nursery, Inc.*, 149 F.Supp. 2d 246, 256–57 (W.D. Va. 2001) (awarding both back-pay and front-pay); *Anglin v. Sears, Roebuck & Co.*, 139 F. Supp. 2d 914, 921 (N.D. Ill. 2001) (granting plaintiff the right to seek restitution in the form of back-pay); *Russell v. Northrop Grumman Corp.*, 921 F. Supp. 143, 152 (E.D.N.Y. 1996) (concluding that back-pay is an equitable remedy).

an equitable remedy, as illustrated by the Tenth Circuit's decision in *Millsap v. McDonnell Douglas Corp.*<sup>44</sup>

In *Millsap*, a class of plan participants alleged that their employer closed one of its manufacturing plants for the illegal purpose under Section 510 of preventing employees who worked at the plant from attaining eligibility for benefits under their retirement and health care plans. After a ten day bench trial, in a "thorough published order...reciting its findings and conclusions,"<sup>45</sup> the district found that the employer's actions violated Section 510,<sup>46</sup> a conclusion that was "undisputed" by the parties when the case eventually reached the Tenth Circuit.<sup>47</sup>

The district court's remedy for the violation of Section 510 was at the heart of the appeal in *Millsap*. The district court awarded \$90 million in backpay to the class of plaintiffs as equitable relief under Section 502(a)(3) because under the circumstances (the plant had been closed since 1993) reinstatement of employment was impossible. On appeal, the Tenth Circuit rejected the district court's remedy, based on the Supreme Court's analysis in *Great-West*, because backpay was not an "equitable" remedy under Section 502(a)(3).<sup>48</sup>

In his dissenting opinion, Judge Lucero of the Tenth Circuit captured perfectly the judicial paradox of *Millsap*.

Under the majority's result, the class plaintiffs are entitled to neither reinstatement nor back pay. Not only does the majority's holding fail to deter ERISA violations, it also encourages employers who violate ERISA to delay proceedings as long as possible, leading to the strange result that...the most egregious offenders could be subject to the least sanctions.<sup>49</sup>

### 3. Fiduciary Irresponsibility

Congress intended ERISA to regulate the conduct of plan fiduciaries who administer employee benefit plans.<sup>50</sup> Among the duties ERISA imposes on plan fiduciaries is the fiduciary duty of prudence.<sup>51</sup> The panel decision in the Fifth Circuit case of *Milofsky*

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44. *Millsap v. McDonnell Douglas Corp.*, 368 F.3d 1246 (10th Cir. 2004).

45. *Id.* at 1248.

46. *Millsap v. McDonnell Douglas Corp.*, 162 F.Supp. 2d 1262, 1298 (N.D. Okla. 2001).

47. *Millsap*, 368 F.3d at 1249.

48. *Id.* at 1260.

49. *Id.* at 1261 (Lucero, J., dissenting) (internal quotations omitted).

50. See 29 U.S.C. §§ 1101–1113 (2000) (listing the fiduciary responsibility provisions of ERISA).

51. 29 U.S.C. § 1104(a)(1)(B). ERISA's other primary fiduciary duties are the duty of loyalty, also known as the exclusive benefit rule, 29 U.S.C. § 1104(a)(1)(A)(i)-(ii), the duty of prudent diversification, 29 U.S.C. § 1104(a)(1)(C), and the duty to follow the terms of the plan unless such terms are inconsistent with the requirements of title I of ERISA, 29 U.S.C.

*v. American Airlines, Inc.*<sup>52</sup> illustrates the controversy concerning ERISA remedies when the alleged breach of a fiduciary duty by an ERISA fiduciary injures less than all of the participants in the plan.

In *Milofsky*, a small regional airline was acquired by the parent company of American Eagle, Inc. ("American Eagle"). At the time of the acquisition, the regional airline had 218 participants in its combination profit sharing and 401(k) retirement plan. These participants were told that their accounts would be transferred to a comparable 401(k) plan sponsored by American Eagle. The fiduciary for the 401(k) plan sponsored by American Eagle allegedly failed to transfer the accounts in a timely and prudent manner, thereby causing the 218 former participants in the regional airline's retirement plan to suffer an investment loss.

These 218 participants were the plaintiffs in *Milofsky*. They brought a claim for breach of fiduciary duty under Sections 409 and 502(a)(2) of ERISA<sup>53</sup> ("Section 409" and "Section 502 (a)(2)," respectively) against the fiduciary for the American Eagle 401(k) plan seeking restoration of the investment losses to their individual plan accounts caused by the fiduciary's breach of fiduciary duty. The Fifth Circuit panel, in a 2-1 decision, affirmed the district court's dismissal of the plaintiffs' claim. The panel majority reasoned that the plaintiffs' claim affected only 218 individual accounts out of the much larger American Eagle 401(k) plan. Therefore, the panel majority concluded, the plaintiffs' could not bring their claim under Sections 409 and 502(a)(2) because the relief sought would not flow to the plan "as a whole."<sup>54</sup>

The panel majority in *Milofsky* noted that the plaintiffs did have standing to bring their claim under Section 502(a)(3) of ERISA. At the same time, the panel majority implicitly acknowledged the futility of such a claim due to the inadequate remedy available, stating:

Section 502(a)(3) is available for individualized relief such as that sought in this case. Though that subsection *explicitly limits recovery to equitable relief and might deny the plaintiffs the particular remedy they desire*, that is all that is available under the remedial

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§ 1104(a)(1)(D).

52. 404 F.3d 338 (5th Cir. 2005).

53. 29 U.S.C. §§ 1109, 1132(a)(2) (2000).

54. *Milofsky*, 404 F.3d at 343-47. The Fifth Circuit's panel decision in *Milofsky* created a split among the circuits concerning whether a subclass of plan participants may bring a breach of fiduciary duty claim under ERISA Sections 409(a) and 502(a)(2). See *In re Schering-Plough Corp. ERISA Litigation*, 420 F.3d 231, 240 (3d Cir. 2005) (permitting a subclass claim under Section 502(a)(2)); *Kuper v. Iovenko*, 66 F.3d 1447, 1453 (6th Cir. 1995) (concluding that plaintiffs may sue as a subclass participant of a plan for breach of fiduciary duty).

scheme designed by Congress. Despite the policy arguments the plaintiffs advance, our task is to apply the text, not to improve upon it.<sup>55</sup>

Judge King dissented from the *Milofsky* panel decision on the ground that the result paradoxically thwarted Congressional intent:

At the end of 2003, over \$2.3 trillion in assets were held in individual account plans, representing well over half of all pension plan assets in the United States. The majority's holding means that those participants in individual account plans who are unfortunate enough to be forced to litigate in the Fifth Circuit will be unable to recover monetary losses to the plans caused by fiduciary breaches when fewer than all plan participants would benefit from the litigation, thereby limiting recovery to the equitable relief available under § 502(a)(3) of ERISA. *To deprive plan participants in such circumstances of a § 409 remedy for breach of fiduciary duty effectively nullifies Congress's intent to provide a high level of protection to any and all plan participants from fiduciary abuse.*<sup>56</sup>

The saga of *Milofsky* did not end with the panel decision. The Fifth Circuit subsequently granted a motion for rehearing en banc.<sup>57</sup> In a cryptic two-page, per curiam opinion, the Fifth Circuit sitting en banc reversed the *Milofsky* panel decision and remanded the case back to the district court for further consideration.<sup>58</sup> The Fifth Circuit's en banc opinion stated only that the plaintiffs were "entitled to further development of their breach of fiduciary duties claims" brought under Section 502(a)(2), and explained that "[m]easured by the principles of notice pleading and the standards controlling dismissal under Fed. R.Civ. P. 12(b)(6)," the district court erred in dismissing these claims.<sup>59</sup>

The underlying substantive issue left unresolved in *Milofsky* is an important one that arises in multiple contexts. The remedy sought by the 218 plan participants in *Milofsky* potentially was unavailable under Section 502(a)(3) because under the Supreme Court's law-equity paradigm, an award of monetary relief for investment losses may not qualify as "equitable" relief.<sup>60</sup> The question of whether monetary relief is available under Section 502(a)(3) arises if breach of fiduciary duty causes either an actual economic loss in value to a participant's retirement account,<sup>61</sup> or

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55. *Milofsky*, 404 F.3d at 346–47 (internal quotations omitted) (footnotes omitted) (emphasis added).

56. *Id.* at 348 (King, J., dissenting) (footnote omitted) (emphasis added).

57. *Milofsky v. American Airlines, Inc.*, 418 F. 3d 429 (5th Cir. 2005).

58. 442 F.3d 311 (2006).

59. *Id.*

60. *See Milofsky*, 404 F.3d at 347 n.23 ("The Supreme Court has indicated that compensatory and punitive damages may not be available under ERISA § 502(a)(3).").

61. The most notorious examples of actual economic loss to participant

the loss of an investment opportunity that results in the slower appreciation of the account's value.<sup>62</sup> A breach of fiduciary duty can cause a participant to pay additional income taxes that could have been avoided if the participant had received complete and accurate tax information concerning the participant's benefit distribution options.<sup>63</sup> A breach of fiduciary duty also can cause the participant to forfeit monetary benefits, such as life insurance benefits or disability benefits, that are paid by an insurer through the employer's plan.<sup>64</sup> In each instance, the end result is the same

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accounts are the Enron, WorldCom, and Global Crossing 401(k) plan cases involving company stock as an investment option. *Goeres v. Charles Schwab & Co.*, 33 Emp. Ben. Cas. 2302 (N.D. Cal. 2004), illustrates a breach of fiduciary duty claim that does not involve allegations concerning company stock as a plan asset. In *Goeres*, an actual economic loss of over \$1 million to allegedly resulted from the plan administrator's negligent refusal to distribute the account balance to the deceased participant's designated beneficiary. *Id.*

62. See *Helfrich v. PNC Bank*, 267 F.3d 477, 481 (6th Cir. 2001) (participant sought monetary award for the difference between what his retirement plan account would have earned if the administrator had transferred his account to higher performing mutual funds in accordance with participant's instructions rather than transferring account to lower performing money market fund); *Kerr v. Charles F. Vatterott & Co.*, 184 F.3d 938, 944 (8th Cir. 1999) (participant sought monetary award for the difference between what his retirement plan account would have earned if the administrator had not wrongfully withheld payment of his account for three and one-half years and what the account actually earned during the period).

63. See *Griggs v. E.I. Dupont de Nemours & Co.*, 385 F.3d 440, 454 (4th Cir. 2004) (affirming order allowing plaintiff to rescind original pay-out of taxable lump sum distribution and elect monthly annuity payment); *Farr v. U.S. West Comm., Inc.*, 151 F.3d 908, 916 (9th Cir. 1998) (seeking among other damages a surcharge equal to taxes paid on lump-sum distribution as a result of defendant's failure to inform plaintiff of income tax consequences of distribution); *Armstrong v. Jefferson Smurfit Co.*, 30 F.3d 11, 12 (1st Cir. 1994) (seeking damages for defendant's failure to inform about income tax ramifications of a lump-sum payment); *Glencoe v. Teachers Ins. and Annuity Ass'n of America*, 69 F. Supp. 2d 849, 852 (S.D. W.Va. 1999) (seeking complete restoration of distributed funds); *Cunningham v. Dun & Bradstreet Plan Servs., Inc.*, 889 F. Supp. 932, 934 (N.D. Miss. 1995) (seeking money damages for tax consequences suffered for plan fiduciary transferred funds); cf. *Fraser v. Lintas*, 56 F.3d 722, 723 (6th Cir. 1995) (dismissing claim under Section 502(a)(1)(B) of ERISA for reimbursement of income taxes paid on lump sum distribution on theory that income taxes were not included in the "benefit due" under the plan).

64. See *Callery v. U.S. Life Ins. Co.*, 392 F.3d 401, 404–05 (10th Cir. 2004) (holding that damages were not available under Section 502(a)(3) against plan administrator who failed to provide accurate information concerning coverage under employer's life insurance plan); *Allinder v. Inter-City Prods. Corp.*, 152 F.3d 544, 550 (6th Cir. 1998) (holding that damages were not available under Section 502(a)(3) against plan administrator who refused to complete form necessary for participant to file claim with insurance company for disability benefits); *Kishter v. Principal Life Ins. Co.*, 186 F. Supp. 2d 438, 445–46 (S.D.N.Y. 2002) (holding that damages were not available under Section 502(a)(3) against plan administrator who failed to provide accurate

– the injury caused by the breach of fiduciary duty results in a lesser benefit amount (or no benefits at all) for the plan participant. To redress the injury, monetary relief is required.

To justify a monetary remedy under Section 502(a)(3), prior to the Supreme Court's decision in *Great-West*<sup>65</sup> some federal courts characterized a monetary award as "restitution."<sup>66</sup> The strong emphasis in *Great-West* on whether the defendant has been unjustly enriched by the claimed misconduct<sup>67</sup> appears to foreclose the possibility of monetary restitution for many types of breach of fiduciary duty claims. For example, if the breach of fiduciary duty involved an imprudent delay in executing a participant's investment direction, or a failure to prudently select and monitor the plan investment options, usually the breaching fiduciary has not been personally enriched. Rather, it is the participant's retirement account that has suffered an investment loss or a lost investment opportunity. Where the breach of fiduciary duty is a failure by the plan fiduciary to explain the adverse income tax consequences associated with a benefit distribution option, it is the United States Treasury, not the plan fiduciary, who is enriched by the failure to disclose. In situations involving insured benefits, the typical fiduciary breach involves either a failure to accurately disclose crucial coverage information or a lack of prudence in preparing or processing the paperwork required to be submitted under the insurance policy to qualify for the plan's benefits. When the insurance company refuses to pay the benefits provided under the policy, it is not the imprudent fiduciary who is enriched, but rather the insurance company, who received the premium payments but who is not obligated under the terms of the insurance policy to make payment of the claimed benefits. In each

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information concerning her coverage under employer's life insurance plan); *Peterman v. Metro. Life Ins. Co.*, 217 F.Supp.2d 807, 809–10 (E.D. Mich. 2002) (holding that monetary relief was unavailable for damages sustained as a result of plan administrator's failure to provide accurate information concerning life insurance policy).

65. *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002).

66. See *Strom v. Goldman, Sachs & Co.*, 202 F.3d 138, 150 (2d Cir. 1999) (discussing the issue of restitution as an equitable remedy); *Fotta v. Trustees of United Mine Workers of Am. Health & Ret. Fund*, 165 F.3d 209, 213–14 (3d Cir. 1998) (noting that restitution is widely recognized as a tool of equity); *Ream v. Frey*, 107 F.3d 147, 153 n.5 (3d Cir. 1997) (allowing claim for restitution of participant's account plus lost investment opportunity costs even though bank as fiduciary was not unjustly enriched); *Howe v. Varity Corp.*, 36 F.3d 746, 756 (8th Cir. 1994) (giving relevant examples of restitution used as a monetary award); *Laurenzano v. Blue Cross and Blue Shield of Mass., Inc. Ret. Income Trust*, 134 F. Supp. 2d 189, 196 (D. Mass. 2001) (pointing out that other equitable remedies, in addition to restitution, take the form of monetary damages).

67. See *Great-West*, 534 U.S. at 212–16 (describing the different views regarding restitution as an equitable remedy compared with a legal remedy).



of these situations, someone *other than the breaching fiduciary* has been “enriched” as a consequence of the fiduciary’s misconduct. If, as *Great-West* suggests, the fiduciary’s unjust enrichment is a prerequisite to equitable restitution under Section 502(a)(3), the injured participant may be left without a remedy under ERISA. Moreover, any state law remedy is likely preempted.<sup>68</sup> In other words, there are numerous contexts in which a plan participant may be “betrayed” by an ERISA fiduciary’s breach of duty, and yet be left “without a remedy.”<sup>69</sup>

#### 4. *Mismanaged Health Care*

My fourth illustration involves the pernicious combination of ERISA’s broad preemption of state law and the limited remedies available under ERISA in the context of benefits decisions made by managed care plans. *Cicio v. Does*<sup>70</sup> illustrates how the judicial paradox operates in the context of these situations, which I refer to as “managed care cases.”

In *Cicio*, the claim was based on the plan’s refusal to provide preauthorization for a medical treatment for cancer that had been recommended by the participant’s treating physician. The plan later authorized an alternative, and less costly, treatment. During the time delay before the alternative treatment was authorized by the plan, the participant’s physical condition deteriorated to the point that further treatment was no longer a viable medical option. Two weeks after the plan authorized the alternative treatment, the participant died.<sup>71</sup>

In managed care cases such as *Cicio*, typically the participant is gravely ill, the medical treatment sought is expensive (hence, the need for preauthorization by the plan to ensure payment), and the plan initially denies the request for preauthorization. The usual justification for denying the requested medical treatment is that the proposed treatment does not satisfy the plan’s requirement that the treatment must be “medically necessary.”<sup>72</sup> If another less costly treatment is available, the plan may propose to pay for the alternative treatment, as was the case in *Cicio*.<sup>73</sup>

The factual scenarios giving rise to managed care cases follow familiar patterns. The less costly treatment authorized by the

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68. See 29 U.S.C. § 1144(a) (2000).

69. *Allinder*, 152 F.3d at 553.

70. 321 F.3d 83 (2d Cir. 2003), *rehearing after remand*, 385 F.3d 156 (2d Cir. 2004).

71. *Cicio*, 321 F.3d at 87–88.

72. See *id.* at 87.

73. *Id.* at 88. In *Cicio*, the treating physician sought preauthorization from the plan to perform high dose chemotherapy with a double stem cell transplant. *Id.* at 87. The plan initially denied this treatment, but later approved the treatment of high dose chemotherapy with a single stem cell transplant. *Id.* at 88.

plan may be less effective and death results.<sup>74</sup> The less costly treatment may cause injury that could have been avoided if the plan had approved the treating physician's original treatment recommendation.<sup>75</sup> Or, the participant's physical condition may deteriorate during the time delay while the plan considers the requested medical treatment to the point where the treatment is no longer a viable medical option.<sup>76</sup> Finally, the plan may not authorize or offer any medical treatment at all. In the most catastrophic of these "no treatment" cases, the participant dies as a result.<sup>77</sup>

In managed care cases, the injured plaintiff (or the plaintiff's estate) usually begins by filing various state law claims in state court. The plan administrator's virtually automatic defense is to remove the case to federal court on the basis of complete preemption under ERISA,<sup>78</sup> followed in short order by a motion to dismiss the plaintiff's state law claims as preempted by ERISA.<sup>79</sup> Often the federal district court judge will permit the plaintiff to amend the original complaint to state a claim for wrongful denial of benefits under ERISA Section 502(a)(1)(B).<sup>80</sup> Most plaintiffs amend the complaint to state an ERISA claim grudgingly due to the remedy available under Section 502(a)(1)(B), which is limited to the benefits that are due under the terms of the plan.

The remedy offered by Section 502(a)(1)(B) in managed care cases provides cold comfort to the widow or widower of the participant, and effectively no compensation for the participant who has incurred personal injury or economic loss as a result of the wrongfully denied claim for medical treatment. The "price" paid for a wrongful denial of a claim for plan benefits is merely

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74. See *Lazorko v. Pennsylvania Hosp.*, 237 F.3d 242, 245–46 (3d Cir. 2000) (mentally ill participant committed suicide when provider did not hospitalize her due to plan's financial incentives discouraging hospitalization); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992) (a nine month old fetus died in the womb when plan administrator substituted ten hours per day of fetal monitoring at home for treating physician's recommended treatment of hospitalization with twenty-four hour fetal monitoring).

75. See *Aetna Health Inc. v. Davila*, 542 U.S. 200, 205 (2004) (adverse drug reaction and post-surgical second hospitalization); *Defelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 468 (3d Cir. 2003) (infection resulting in hospitalization).

76. See *Cicio v. Does*, 321 F.3d 83, 88 (2d Cir. 2003) (participant later died); *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 270 (3d Cir. 2001) (participant suffered permanent chronic back pain).

77. See *Bauman v. U.S. Healthcare, Inc.*, 193 F.3d 151, 156 (3d Cir. 1999) (infant discharged twenty-four hours after birth developed meningitis and died within forty-eight hours of birth); *Dukes v. U.S. Healthcare*, 57 F.3d 350, 352 (3d Cir. 1995) (failure of plan physician to authorize diagnostic blood test resulted allegedly in participant's death).

78. See *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987).

79. See 29 U.S.C. § 1144(a) (2000).

80. 29 U.S.C. § 1132(a)(1)(B) (2000) ("Section 502(a)(1)(B)").

what the plan should have paid according to the terms of the plan. Such a limited remedy:

eliminates an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system. With liability rules generally inapplicable, there is theoretically less deterrence of substandard medical decisionmaking. Moreover, if the cost of compliance with a standard of care (reflected either in the cost of prevention or the cost of paying judgments) need not be factored into utilization review companies' cost of doing business, bad medical judgments will end up being cost-free to the plans that rely on these companies to contain medical costs. ERISA plans, in turn, will have one less incentive to seek out the companies that can deliver both high quality services and reasonable prices.<sup>81</sup>

##### *5. Increased Plan Costs for Employers*

Managed care cases under ERISA have attracted public attention because these cases present compelling stories and involve sympathetic plaintiffs. Less sympathetic, but equally compelling from the perspective of employers who sponsor employee benefit plans for their employees, is the adverse impact of the judicial paradox on plan administration and the ability of the plan administrator to enforce the terms of the plan.

Although ERISA's primary goal was to protect the benefits of plan participants, Congress's secondary goal in enacting ERISA was to encourage the growth of employer-sponsored benefit plans by avoiding undue administrative burdens that might deter voluntary plan sponsorship.<sup>82</sup> This secondary goal is supported by the broad preemption of state laws under ERISA Section 514(a).<sup>83</sup> Congress intended ERISA preemption of state laws to result in uniform federal standards that would reduce the complexity and related costs of plan administration for employers who operated in multiple jurisdictions.<sup>84</sup>

Uncertainty concerning the availability of equitable relief under Section 502(a)(3) to enforce the terms of the employer's plan has led to increased plan administrative costs in a variety of contexts. For example, employers who offer health care plan benefits to their employees often do so through self-insured health

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81. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1338 (5th Cir. 1992).

82. *See Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262–63 (1993) (noting the competing nature of these two goals).

83. 29 U.S.C. § 1144(a).

84. *See* 29 U.S.C. § 1001(b) (2000); *Egelhoff v. Egelhoff*, 532 U.S. 141, 150 (2001) (recognizing the burden that ERISA's preemption rule was designed to avoid).

care plans.<sup>85</sup> When a self-insured plan pays for the medical care of a participant who has been injured, the terms of the plan usually require that the participant must reimburse the plan for the medical expenses paid for by the plan if the participant later recovers from the third-party tortfeasor who caused the participant's injuries.<sup>86</sup> If the injured plan participant later recovers against the tortfeasor, the participant may refuse to reimburse the plan. To enforce the terms of the plan, the plan administrator must sue the participant for "equitable relief" under Section 502(a)(3) to compel reimbursement.

Claims against a plan participant to compel reimbursement also arise in the context of disability benefit plans where the participant later receives a retroactive payment of Social Security disability benefits,<sup>87</sup> or instances where the plan administrator mistakenly has made an overpayment of benefits to the participant. In each of these circumstances, the ability of the plan administrator to effectively enforce the terms of the plan through a claim for reimbursement may be uncertain due to the Supreme Court's decisions in *Great-West Life & Annuity Insurance Co. v. Knudson*<sup>88</sup> and *Sereboff v. Mid Atlantic Medical Services, Inc.*<sup>89</sup>

The facts of *Great-West* illustrate the high litigation costs often associated with the enforcement of a health care plan reimbursement clause. The main defendant in *Great-West* ("Knudson") had health care coverage through a health care plan sponsored by her husband's employer. Knudson became a quadriplegic as the result of a car accident, incurring \$411,157.11 in medical expenses. Of this amount, the employer's self-insured plan paid \$75,000, and the remainder was paid by the plan's stop-loss insurance carrier ("Great-West").<sup>90</sup> Knudson filed a tort action in state court against various alleged tortfeasors to recover for her injuries. The parties to this state court action negotiated a settlement of \$650,000. Notice of this proposed state court settlement was mailed to Great-West as the assignee of the plan fiduciary's right to enforce the terms of the reimbursement clause.<sup>91</sup> Great-West attempted unsuccessfully to remove the state court tort action to federal court. The state court later approved the settlement agreement.<sup>92</sup> Under the terms of the settlement

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85. See Medill, *supra* note 24, at 496.

86. See generally THOMAS H. LAWRENCE & JOHN M. RUSSELL, ERISA SUBROGATION: ENFORCING RECOUPMENT PROVISIONS IN ERISA-COVERED WEALTH AND DISABILITY PLANS (1999).

87. See discussion *infra* Part III.C.3.d.

88. 534 U.S. 204 (2002).

89. 126 S.Ct. 1869 (2006).

90. *Great-West*, 534 U.S. at 207-08.

91. *Id.* This assignment gave plaintiff Great-West derivative standing to assert the plan's fiduciary's claim under Section 502(a)(3). *Id.*

92. *Id.* at 208.

agreement, Great-West received \$13,828.70 for past medical expenses paid by the plan.

The die was cast in the *Great-West* litigation when the state court approved the terms of the tort settlement agreement. Under the settlement agreement, payment by the tort defendants was structured so that \$256,745 of the settlement proceeds were paid directly to a special needs trust.<sup>93</sup>

Great-West refused to cash the check it received for \$13,828.70, its share of the tort settlement proceeds. Instead, Great-West filed a claim in federal district court seeking "injunctive and declaratory relief" under Section 502(a)(3). Great-West sought to enforce the plan's reimbursement clause against Knudson through a court order requiring Knudson personally to reimburse the plan.<sup>94</sup> In a 5-4 decision, the Supreme Court rejected the claim to enforce the terms of a reimbursement clause against Knudson under Section 502(a)(3) because "to impose personal liability on [the plan participant] for a contractual obligation to pay money [is] relief that was not typically available in equity."<sup>95</sup>

*Great-West* is paradoxical on several levels. *Great-West* has made it difficult and costly for employers who sponsor health care plans to enforce a reimbursement clause and recoup the plan's medical expenses that have been recovered by a participant in a tort action in state court.<sup>96</sup> Even the most elite of ERISA lawyers, who make their living litigating ERISA's complexities, find daunting the procedural and substantive barriers that *Great-West* presents for the enforcement of a plan reimbursement clause.<sup>97</sup>

More fundamentally, *Great-West*, is paradoxical because even though the Supreme Court purported to reaffirm its earlier decision in *Mertens v. Hewitt Associates*,<sup>98</sup> the rationales of the two decisions are inapposite from a policy perspective. The explicit

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93. *Id.* at 207-08. A special needs trust is a common law express trust containing a distribution provision that authorizes the trustee only to distribute trust assets for the "special" needs of the trust beneficiary, and prohibits the trustee from distributing trust assets for any necessities (such as medical care) that are provided by government programs (such as Medicaid).

94. *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 208 (2002).

95. *Id.* at 210.

96. See Robert N. Eccles & David E. Gordon, *Great-West Life & Annuity Ins. Co. v. Knudson: Supreme Court Announces That It Was Not Kidding in Mertens v. Hewitt Associates*, ERISA LIT. REP (Glasser Legal Works), Feb. 2002, at 3; Robert N. Eccles & David E. Gordon, *Great-West Life - The First 100 Days*, ERISA LIT. REP (Glasser Legal Works), April 2002, at 1.

97. See *Supreme Court Announces That It Was Not Kidding*, *supra* note 96, at 3 ("[W]e are all somewhat baffled about what to do the next time a plan wants to be repaid for medical expenditures on behalf of a participant who has recovered from a tortfeasor.").

98. 508 U.S. 248 (1993).

policy rationale relied upon by the Supreme Court in *Mertens* was to avoid increasing the costs to employers of sponsoring benefit plans.<sup>99</sup> In contrast, the majority in *Great-West* simply ignored the countervailing policy argument that the consequence of thwarting the plan's ability to enforce a reimbursement clause by denying a remedy under Section 502(a)(3) would be to increase the costs to employers of sponsoring health care plans for their employees.<sup>100</sup>

Unlike *Great-West*, *Sereboff v. Mid Atlantic Medical Services, Inc.*<sup>101</sup> presented a relatively simple set of facts. Joel and Marlene Sereboff were participants in an employer-sponsored health care plan that contained a reimbursement clause. The Sereboffs, who were residents of Maryland, were injured in an automobile accident and later recovered a settlement from the tortfeasor who caused their injuries. Throughout the tort litigation, the health care plan asserted its right to reimbursement from the Sereboffs if the Sereboffs prevailed. When parties settled the tort litigation, the settlement proceeds were divided between the Sereboffs' California tort attorney as payment for attorney's fees and the Sereboffs.

Using their share of the tort settlement proceeds, the Sereboffs placed the exact amount claimed by the health care plan for reimbursement into a separate investment account. When the Sereboffs refused voluntarily to reimburse the health care plan, the health care plan filed a claim against the Sereboffs under Section 502(a)(3) seeking equitable relief. In *Sereboff*, the particular form of equitable relief sought by the plan was an equitable lien or a constructive trust on the settlement proceeds held in the Sereboffs' investment account. The Supreme Court in *Sereboff* held that the health care plan's remedy in the form of an equitable lien "based on an agreement" (i.e., based on the terms of the health care plan) concerning the funds held in the investment account was "equitable" relief within the meaning of Section 502(a)(3).<sup>102</sup>

Unlike *Great-West*, in *Sereboff* the reimbursement claim was limited to a separate and identifiable fund controlled by the plan participants and the fund had adequate assets fully to reimburse the plan.<sup>103</sup> The very simplicity of the facts in *Sereboff* leaves unresolved several issues that swirl around the equitable lien or constructive trust remedy. These issues are likely to arise in the context of more sophisticated variations on the basic fact pattern in *Sereboff*. For example, the tort recovery funds held by the

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99. *Mertens*, 508 U.S. at 262–63.

100. See Daniel J. Meltzer, *The Supreme Court's Judicial Passivity*, 2002 SUP. CT. REV. 343, 350 (2002).

101. 126 S.Ct. 1869 (2006)

102. *Id.* at 1874–75.

103. *Id.* at 1873.

participant may not be sufficient fully to reimburse the plan, and the plan administrator may seek to recover part of the tort recovery funds paid to the participant's tort attorney as attorney's fees.<sup>104</sup> Or, the tort recovery funds may be paid directly from the tortfeasor to the trustee of an express trust established for the benefit of the participant, as was the case in *Great-West*. In addition, the participant, the participant's tort attorney, or the participant's trustee may commingle the tort recovery funds with other assets, or spend the funds, and then assert that a separate fund no longer exists upon which an equitable lien or a constructive trust may be imposed. These more sophisticated variations on *Sereboff* are all ways that a plan participant may seek to avoid the obligation to reimburse the plan.

In attempting to clarify *Great-West*,<sup>105</sup> which emphasized the technical nuances of remedies available in common law courts of equity, the Supreme Court's decision in *Sereboff* leaves employers, plan administrators, and the lower federal courts without clear guidance as to how far equitable relief in the form of an equitable lien or a constructive trust under Section 502(a)(3) extends. Although the Supreme Court in *Sereboff* rejected the contention that *Great-West* "endorsed application of *all* the restitutionary conditions" required to be satisfied before a court of equity would award relief,<sup>106</sup> *Sereboff* leaves unresolved the fundamental question of exactly when strict compliance with the technical requirements of the common law for equitable relief is required. The resulting uncertainty is likely to lead to years of costly litigation as the lower federal courts attempt to apply *Great-West* and *Sereboff* to different factual situations.

#### 6. Judicial Frustration (and Congressional Passivity)

As these cases illustrate, the Supreme Court's interpretation of "equitable relief" under Section 502(a)(3) is "one of the critical issues that dominates much of ERISA litigation."<sup>107</sup> Not surprisingly, federal judges have begun to express their own growing sense of frustration with the judicial paradox of ERISA remedies.<sup>108</sup> The unanimous panel opinion by Judges Moore, Clay

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104. See *Bombardier Aerospace Employee Welfare Benefits Plan v. Ferrer*, 354 F.3d 348, 357 (5th Cir. 2003); *Admin. Comm. of the Wal-Mart Assocs. Health & Welfare Plan v. Varco*, 338 F.3d, 680, 683-84 (7th Cir. 2003); *Hotel Employees Int'l Union Welfare Fund v. Gentner*, 50 F.3d 719, 723 (9th Cir. 1995); *Greenwood Mills, Inc. v. Burris*, 130 F.Supp.2d 949, 958 (M.D. Tenn. 2001).

105. See *Sereboff*, 126 S.Ct. at 1874 (explaining how the facts of *Great-West* made the relief sought not "equitable").

106. 126 S.Ct. at 1876 (emphasis added).

107. Robert N. Eccles & David E. Gordon, *Under the Radar*, ERISA LIT. REP. (Glasser Legal Works), Oct. 2001, at 1-2.

108. See *Farr v. U.S. West Communications*, 151 F.3d 908, 917 (9th Cir.

and Gilman of the Sixth Circuit in *Allinder v. Inter-City Products Corp.*<sup>109</sup> is typical of this judicial sentiment:

Many commentators have noted that the Supreme Court's 5-4 decision in *Mertens* has resulted in a "betrayal without a remedy" for employees who pursue ERISA claims beyond the simple recovery of benefits. The outcome in this case lends support to such criticism. [The plaintiff-participant] would have been entitled to monetary damages under the state-law claims she originally filed. These claims, however, were extinguished by ERISA's ever-expanding preemptive black hole. ERISA, in turn, provides infertile soil for an employee to cultivate a meaningful remedy for anything beyond the recovery of basic benefits. Employees may seek monetary damages on behalf of the *plan* for an employer's breach of fiduciary duty. They may not, however, seek similar relief for their own benefit when an employer breaches its fiduciary duty. Instead, employees are left with the often-inadequate remedy of an injunction, imposition of a constructive trust, or the removal of the fiduciary. In this way, the combination [of the employee's] state cause of action [being] preempted by ERISA even while ERISA denies him any alternative remedy. . . is disappointingly pernicious to the very goal and desires that motivated Congress to enact [ERISA] in the first place.

Constrained as we are by both ERISA's statutory provisions and the Supreme Court's construction of that language, this case provides no

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1998) (Hawkins, J., specially concurring) ("We have faithfully applied *Mertens* and its restrictive interpretation of § 502(a)(3). . . [A]s this case so aptly demonstrates, perhaps Congress should rethink the limited remedies provided in § 502 and afford a greater range of relief to beneficiaries when a fiduciary so clearly breaches its duties."); *Bast v. Prudential Ins. Co. of America*, 150 F.3d 1003, 1011 (9th Cir. 1998) ("The Bast's state law claims are preempted by ERISA, and ERISA [Section 502(a)(3)] provides no remedy. Unfortunately, without action by Congress, there is nothing we can do to help the Bast and others who may find themselves in this same unfortunate situation."); *Cunningham v. Dun & Bradstreet Plan Servs., Inc.*, 889 F. Supp. 932, 937 (N.D. Miss. 1995) ("It does not appear that the plaintiff has any remedy for what may be a grievous wrong against her. This is the sad truth of the present state of ERISA law."); *Metropolitan Life Ins. Co. v. Socia*, 16 F. Supp. 2d 66, 73 (D. Mass. 1998) ("[ERISA] does not always vindicate traditional notions of justice, either for the plan or for its participants."); *Andrews-Clark v. Travelers Ins. Co.*, 984 F. Supp. 49, 63 (D. Mass. 1997) ("Under any criterion. . . the shield of near immunity now provided by ERISA [to HMO plans] simply cannot be justified."). In *Suggs v. Pan Am. Life Insurance Co.*, the court summarized the sense of judicial frustration:

[T]he overriding purpose of the judiciary is to provide justice. When Congress passes legislation. . . "to protect. . . the interests of participants in private pension plans and their beneficiaries". . . and yet the Courts have to say "for what may have been a serious mistake there is no remedy, state or federal". . . something is wrong. The system isn't working.

*Suggs v. Pan Am. Life Ins. Co.*, 847 F. Supp. 1324, 1357 (S.D. Miss. 1994).

109. 152 F.3d 544 (6<sup>th</sup> Cir. 1998).



opportunity for us to redress the problems that employees face when pursuing a remedy under ERISA for an employer's or insurer's misdeeds beyond the recovery of the basic benefits to which they are entitled. . . .<sup>110</sup>

One proposed solution is for the Supreme Court to reconsider its interpretation of equitable relief and broaden the availability of monetary relief under Section 502(a)(3).<sup>111</sup> For managed care cases in particular, it is the lack of a consequential damages remedy under ERISA that drives the plaintiff's legal strategy.<sup>112</sup> Efforts by plaintiffs' lawyers to avoid ERISA preemption of state law malpractice claims, and thereby preserve a consequential damages remedy under state law, have resulted in a body of caselaw under ERISA that Judge Becker of the Third Circuit has characterized as a "Serbonian bog" – "a mess from which there is no way of extricating oneself."<sup>113</sup> In *Difelice v. Aetna U.S. Healthcare*,<sup>114</sup> Judge Becker summarized the growing sense of judicial frustration with ERISA managed care cases in stark terms:

The vital thing. . . is that either Congress or the Supreme Court act quickly, because the current situation is plainly untenable. Lower courts are routinely forced to dismiss entirely justified complaints by plan participants who have been grievously injured by HMOs and plan sponsors, all because of ERISA, the very purpose of which was to safeguard those very participants. Our dockets grow increasingly crowded with cases where participants offer myriad varieties of artful pleadings in their desperate attempts to circumvent ERISA's procrustean reach, and our caselaw grows

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110. *Id.* at 553 (citations and quotations omitted) (emphasis added).

111. See discussion *infra* Part III.D.3.

112. See *Cicio v. Does*, 321 F.3d 83, 106 (2d Cir. 2003), *rehearing after remand*, 385 F.3d 156 (2d Cir. 2004) (Calabresi, J., dissenting). Judge Calabresi succinctly described the problem presented by the lack of a damages remedy.

The conclusion that my colleagues have reached today is a band-aid on a gaping wound. It may provide justice to Mrs. Cicio, and I'm glad for that, but the injury that the courts have done to ERISA will not be healed until the Supreme Court reconsiders the existence of consequential damages under the statute, or Congress revisits the law to the same end.

*Id.* Unfortunately for Mrs. Cicio, the "band-aid" – the Second Circuit's ruling that her state law claim of medical malpractice against the HMO was not preempted by ERISA – was torn off when the Supreme Court remanded her case for further consideration in light of the Court's opinion in *Aetna Health, Inc. v. Davila*, 542 U.S. 200 (2004). Upon reconsideration after remand, the Second Circuit panel concluded that "*Aetna Health Inc.* fatally undermines our reasoning in the [prior] panel decision," and dismissed the plaintiff's state law claim of medical malpractice as preempted by ERISA. *Cicio v. Does*, 385 F.3d 156, 158 (2d Cir. 2004).

113. See *Difelice v. Aetna U.S. Healthcare*, 346 F.3d 442, 454 & n. 1 (Becker, J., concurring).

114. *Id.*

massively inconsistent due to the sheer complexities of the subject and lack of any meaningful guidance. There must a better way.<sup>115</sup>

In a futile attempt to provoke a dialogue with Congress and the Department of Labor on the issue,<sup>116</sup> Judge Becker further ordered that

the Clerk of Court is directed to send a copy of this opinion. . .to the Solicitor of the Department of Labor; the Chair, Ranking Member, Chief Majority Counsel, and Minority Counsel of the Senate Committee on Health, Education, Labor, and Pensions; and the Chair, Ranking Member, Chief Majority Counsel, and Minority Counsel of the House Committee on Education and the Workforce.<sup>117</sup>

Most recently, in *Aetna Health, Inc. v. Davila*<sup>118</sup> Supreme Court Justices Ruth Bader Ginsburg and Stephen G. Breyer joined “the rising judicial chorus urging that Congress and [this] Court revisit what is an unjust and increasingly tangled ERISA regime.”<sup>119</sup> To date, these judicial pleas for statutory reform have fallen on deaf ears. Why has Congress not responded to these expressions of judicial frustration? The answer lies, at least in part, in the complex interest group politics that surround ERISA.<sup>120</sup>

Although most public and judicial attention has been focused on ERISA managed care cases, the cases presented illustrate that Section 502(a)(3) cuts a much wider swath than merely claims concerning mixed medical treatment and benefits eligibility decisions by managed care plans. Consequently, any attempt by Congress to amend Section 502(a)(3) is likely to face significant opposition from numerous stakeholders in the employee benefits system. These interested stakeholders include: employers; labor unions; the financial services industry (whose members serve as plan administrators and trustees and who also provides various investment products for retirement plans); the insurance industry; the health care industry; health care providers; and the plaintiff's tort bar. For every stakeholder who advocates for a change by Congress regarding the remedies available under Section

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115. *Id.* at 467.

116. See GUIDO CALABRESI, A COMMON LAW FOR AN AGE OF STATUTES, 165–66 (1982) (“In a statutory world, . . . the appropriate technique [to deal with a statute that has become obsolete] will be to enter into a dialogue, to ask, cajole, or force another body (usually the legislature but sometimes the agencies) to define the new rule or reaffirm the old.”).

117. *Difelice*, 346 F.3d at 467.

118. 542 U.S. 200 (2004).

119. *Id.* at 222 (Ginsburg, J., concurring) (internal quotations and citations omitted).

120. See Judith Resnick, *Constricting Remedies: The Rehnquist Judiciary, Congress, and Federal Power*, 78 IND. L. REV. 223, 269 n.253 (2003) (noting that interest group politics complicate proposals to amend ERISA).

502(a)(3), there is another stakeholder who benefits from, and therefore seeks to preserve, the status quo.

The complex interest group politics surrounding ERISA have led Congress to exhibit its own brand of passivity when it comes to amending ERISA. For two current examples, one need look no further than legislative proposals to limit the concentration of company stock permitted in 401(k) plans in the wake of the Enron scandal, and legislative proposals to provide greater federal rights to patients in managed health care plans. Despite obvious problems and strongly favorable public sentiment, Congress has failed to enact reform legislation in either area.

Congress similarly is unlikely to respond to calls for reform by the federal judiciary because Section 502(a)(3) represents the proverbial politician's Pandora's box – impossible to open without unleashing a host of swarming lobbyists from interested stakeholder groups upon the members of Congress. The inability (or unwillingness) of members of Congress to achieve consensus among various stakeholder groups concerning reform means that if the paradox of equitable remedies under ERISA is to be resolved, it must be resolved by the very institution that has created the paradox – the Supreme Court itself.

### *B. Scholarly Criticism and the Need for a Better Doctrinal Theory*

Although a substantial body of academic literature has developed on the subject of ERISA remedies, prior scholars generally have focused their efforts on the application of Section 502(a)(3) to specific types of claims.<sup>121</sup> An exception is Professor

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121. The scholarly literature to date on ERISA Section 502(a)(3) has focused more narrowly on specific issues. Scholars have focused on the plight of plan participants "betrayed without a remedy." See Randall J. Gingiss, *The ERISA Foxtrot: Current Jurisprudence Takes One Step Forward and One Step Back in Protecting Participants' Rights*, 18 VA. TAX REV. 417, 417–72 (1998) (describing the plight of plan participants whom are left with an inequitable remedy under ERISA); Jayne Elizabeth Zanglein, *Closing the Gap: Safeguarding Participants' Rights by Expanding the Federal Common Law of ERISA*, 72 WASH. U.L.Q. 671, 671–23 (1994) (criticizing the Supreme Court's interpretation of ERISA which deprives plan participants of remedies that existed prior to ERISA); George Lee Flint, Jr., *ERISA: Extracontractual Damages Mandated for Benefit Claims Actions*, 36 ARIZ. L. REV. 611, 611–66 (1994) (describing the problem with Section 502(a) and outlining the proper analysis courts should use to determine whether extra contractual damages are permissible). Scholars have focused on the availability of a monetary award in breach of fiduciary duty cases. See generally Eduard A. Lopez, *Equitable Remedies for Breach of Fiduciary Duty Under ERISA After Varity Corp. v. Howe*, 18 BERKELEY J. EMP. & LABOR L. 323, 323–46 (1997); John D. Shire, Note, *Varity Corp. v. Howe in the Wake of Mertens v. Hewitt Associates: Did the Supreme Court Impermissibly Authorize a Damages Award Under ERISA Section 502(a)(1)(B)?*, 102 DICKINSON L. REV. 411, 411–39 (1998); Note, *Closing the Massachusetts Mutual v. Russell Gap: Monetary Damage Awards Under ERISA Section 502(a)(3)*, 48 WASH. & LEE L. REV. 691, 691–22 (1991).

John H. Langbein's article, *What ERISA Means By "Equitable": The Supreme Court's Trail of Error in Russell, Merten, and Great-West*.<sup>122</sup> In his article, Professor Langbein meticulously destroys the legal reasoning that justifies the Supreme Court's law-equity paradigm as a foundational theory for defining the types of equitable relief available under Section 502(a)(3). Professor Langbein powerfully concludes:

The Supreme Court needs to confess its error in ERISA remedy law, much as it has recently confronted its mishandling of ERISA preemption, and to realign ERISA remedy law with the trust remedial tradition that Congress intended in the grant of "appropriate equitable relief." It was error to say that mandamus was an equitable remedy; mandamus was always legal and never equitable. It was error to say that money damages never lay for equitable causes of action; our courts award damages for breach of trust and for other equitable causes of action every day. It was error to say that a Congress sitting in 1974 meant to unravel forty years of fusion of law and equity, solely by employing the benign sounding word "equitable" when authorizing "appropriate equitable relief." It was error to confuse the routine judicial work of applying so abstract a term as "appropriate equitable relief" with the forbidden activity of implying omitted statutory provisions. Congress federalized the law of pension and benefit plan administration for the primary purpose of protecting plan participants and beneficiaries through a triple regime of mandatory trusteeship, extensive fiduciary duties, and commensurate remedies.<sup>123</sup>

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See also Susan J. Stabile, *Breach of ERISA Fiduciary Responsibilities: Who's Liable Anyway?*, 5 EMP. RTS. & EMP. POL'Y J. 135 (2001) (discussing claims against nonfiduciaries who assist in a fiduciary's breach of duty); Susan J. Stabile, *I Believed my Employer and Didn't Sell my Company Stock: Is There an ERISA (or '34 Act) Remedy for Me?*, 36 CONN. L. REV. 385 (2003–2004) (discussing remedies for fiduciary breach of duty related to company stock held in a 401(k) plan). Scholars also have focused on fiduciary claims for contribution or indemnity. See generally George Lee Flint, Jr. & Philip W. Moore, Jr., *ERISA: A Co-Fiduciary Has No Right to Contribution and Indemnity*, 48 S. D. L. REV. 7 (2003); Note, *A Fiduciary's Right to Contribution or Indemnity Under ERISA*, 21 OKLA. CITY U. L. REV. 507, 507–74 (1996); Comment, *Fairness and Efficiency: Allowing Contribution Under ERISA*, 80 CAL. L. REV. 1543, 1543–94 (1992); Michael J. Collins, *It's Common, But Is It Right? The Common Law of Trusts In ERISA Fiduciary Litigation*, 16 LAB. LAW 391, 412–21 (2001). Still other scholars have focused on claims for retaliation or the enforcement of plan reimbursement clauses. See, e.g., Dana M. Muir, *ERISA Remedies: Chimera or Congressional Compromise?*, 81 IOWA L. REV. 1, 1–53 (1995) (discussing claims alleging employer retaliation); John R. Cella, Jr., *The Pursuit of Proceeds by Plans, Participants and Plaintiffs' Lawyers: Dissonant Solutions to an Alliterative Problem*, 22 CAMPBELL L. REV. 317, 317–39 (2000) (discussing claims for reimbursement of benefits paid by health care plans).

122. Langbein, *supra* note 13.

123. *Id.* at 1365–66.

Professor Langbein proposes that the make-whole relief tradition developed under the law of trusts should replace the Supreme Court's law-equity paradigm in cases where the claim under Section 502(a)(3) is one for breach of ERISA fiduciary duties.<sup>124</sup> Under a make-whole standard of equitable relief, an individual who is injured by a fiduciary's breach of duty may recover "money damages for consequential injury" under Section 502(a)(3).<sup>125</sup>

Professor Langbein's article focuses on the most significant category of claims – breach of fiduciary duty claims – and proposing a substitute doctrinal theory for determining "equitable" relief in these cases. Professor Langbein's article does not, however, purport to provide a universal solution to the judicial paradox of ERISA remedies. Over thirty years of experience with ERISA demonstrates that there are a variety of claims possible under Section 502(a)(3), and not all of these claims involve allegations of a breach of ERISA fiduciary duty.<sup>126</sup> These nonfiduciary claims exist in part because, although Congress generally intended ERISA to codify the principles of fiduciary conduct developed under the common law of trusts, Congress also recognized that modifications to the common law of trusts were necessary for the modern world of employee benefit plans.<sup>127</sup> Thus, Section 502(a)(3) encompasses not only claims for a breach of ERISA's statutory fiduciary duties, but also claims *based on a violation of other statutory provisions of title I of ERISA, or a violation of the terms of an ERISA plan*.<sup>128</sup>

It is this variety of possible claims that makes interpretation of Section 502(a)(3) so challenging for the federal judiciary. As a doctrinal theory, the common law of trusts becomes a less compelling basis for the interpretation of equitable relief available under Section 502(a)(3) in the context of claims that are not closely related to the trustee-based roots of ERISA. The combination of

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124. *Id.* at 1324–38.

125. *Id.* at 1333–34, 1365–66.

126. See discussion *supra* Parts II.A.1.–5.

127. See H.R. REP. NO. 93-533 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4649-51 (adopting appropriate modifications for employee benefit plans); S.REP. NO. 93-127 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4838, 4866 (recognizing that appropriate modifications must be made for employee benefit plans); H.R. REP. NO. 93-1280 (1973), *reprinted in* 1974 U.S.C.C.A.N. 5038, 5076 (detailing those modifications necessary for modern employee benefit plans); *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996) (acknowledging that ERISA's standards and procedures reflect Congress's determination that the common law of trusts was not appropriate protection for employee benefit plans). Indeed, Professor Langbein acknowledges and describes various instances where ERISA omitted areas of trust law that were inapplicable or inappropriate for employee benefit plans. See Langbein, *supra* note 13, at 1327–28.

128. See 29 U.S.C. § 1132(a)(3) (2000).

fiduciary claims not strongly linked to the common law of trusts, such as claims against plan participants, claims against nonfiduciary plan service providers, and claims against third parties, has made judicial interpretation of Section 502(a)(3) a complex task.

The remainder of the Article explores and illuminates the current theoretical void. The Article develops a statutory and policy-based theory that reconciles Professor Langbein's proposed make-whole relief in the context of fiduciary claims with the other types of claims, also authorized by Section 502(a)(3), that are not strongly rooted in the common law of trusts and trustees.

### *C. Resolving the Paradox Through Slippery Slope Theory*

#### *1. The Supreme Court's Perception of Section 502(a)(3) as a Slippery Slope*

Two yearnings influence development of any legal rule. One is the yearning for a precise rule that serves as an unfailing guide to the judge in making decisions and to the lawyer in predicting them. The other is the yearning for a flexible rule that is most conducive to sensitively administered justice – a rule that never compels bad decisions in the interest of symmetry, elegance, or simplicity.<sup>129</sup>

In the above quotation, Robert Keeton perfectly captures the interpretive dilemma that lurks underneath Section 502(a)(3). The authority of federal judges to award “appropriate equitable relief” under Section 502(a)(3) provides tremendous flexibility to tailor a remedy that achieves a fair and just result in any given case. Yet this very flexibility also represents the potential for chaos. Without clear guidelines, each new case will bring arguments from the parties that the federal court should award the most generous remedy, or the most stingy one (including no remedy at all), based on prior precedents under Section 502(a)(3).

The dilemma presented by the vague wording of Section 502(a)(3) is suggestive of the classic judicial slippery slope – the situation where one judicial decision potentially may lead to another through the force of judicial precedent.<sup>130</sup> My claim in this part of the Article is that the judicial paradox of ERISA remedies arose, at least in part,<sup>131</sup> because of the mistaken perception that

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129. ROBERT KEETON, *LEGAL CAUSE IN THE LAW OF TORTS*, vii (1963).

130. See Eugene Volokh, *The Mechanisms of the Slippery Slope*, 116 HARV. L. REV. 1026, 1034 (2003).

131. Professor Judith Resnick has posited that the Supreme Court's interpretation of equitable relief under Section 502(a)(3) is merely a subterfuge for judicial hostility toward an apparently open-ended remedies provision. See Resnick, *supra* note 120, at 258–61 (describing *Great-West* as symptomatic of the Supreme Court's general tendency to read the remedies provisions of federal statutes in a restrictive fashion, thereby limiting the

Section 502(a)(3) is fraught with the dangers traditionally associated with a judicial slippery slope. To eliminate these perceived dangers, it appears that the Supreme Court has opted for the lesser of two evils: a “one-size-fits-all” judicial interpretation, justified by the Court’s law-equity paradigm. The law-equity paradigm may provide a precise and easily administered rule, but it is a rule that in application frequently offends judicial notions of fairness and justice.

The Supreme Court’s perception of Section 502(a)(3) as presenting a judicial slippery slope is made most transparent in the debate between the majority and dissenting Justices in *Great-West*.<sup>132</sup> In *Great-West*, as in *Mertens*,<sup>133</sup> a five Justice majority viewed Congress’s use of the word “equitable” in Section 502(a)(3) as signaling Congressional intent to limit the scope of relief available.<sup>134</sup> The only way to give this limitation substance, the *Great-West* majority concluded, was to incorporate the historical distinctions between remedies at law and remedies in equity into the statute. In the words of the majority in *Great-West*:

[i]t is easy to disparage the law-equity dichotomy as “an ancient classification,” and an “obsolete distinctio[n].” Like it or not, however, that classification and distinction has been specified by the statute; and there is no way to give the specification meaning — indeed, there is no way to render the unmistakable limitation of the statute a limitation *at all*— except by adverting to the differences between law and equity to which the statute refers.<sup>135</sup>

The dissenting Justices in *Great-West* proposed an alternative approach to the interpretation of equitable relief available under Section 502(a)(3). Under this alternative approach, the federal courts would “look to the substance of the relief requested”<sup>136</sup> and construe the term “equity” in a flexible manner that would be

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scope of federal relief available to vindicate violations of federal rights). Professor Daniel Meltzer has suggested that the Supreme Court’s interpretation of equitable relief under Section 502(a)(3) is symptomatic of a selective judicial passivity toward judicial lawmaking in subconstitutional areas of federal law. See Meltzer, *supra* note 100, at 346–51. Although not ruling out the possibility of mixed motives by the Justices, I am proposing a more benign explanation, namely that even Supreme Court Justices sometimes have difficulty with a complex federal statute, and that the Supreme Court’s interpretation based on the law-equity justification is a plausible judicial response to the perceived dangers of a judicial slippery slope.

132. *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002).

133. *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993).

134. See *Great-West*, 534 U.S. at 209–10 (stating that “[e]quitable’ relief must mean *something* less than *all* relief.” (quoting *Mertens*, 508 U.S. at 259 n.8)).

135. *Great-West*, 534 U.S. at 216–17 (citations omitted)(emphasis in original).

136. *Id.* at 228.

dependent on the context and circumstances of the case.<sup>137</sup> The majority in *Great-West* dismissed this alternative approach, stating that “[w]hat *will* introduce a high degree of confusion into congressional use (and lawyers’ understanding) of the statutory term ‘equity’ is the *rolling revision of its content* contemplated by the dissents.”<sup>138</sup>

The majority’s concern in *Great-West* that a context-specific approach to equitable relief available under Section 502(a)(3) would result in a “rolling revision” of the statutory language stems from the assumption, apparently shared by all nine Justices, that there are virtually no limits to the type of defendants and related claims cognizable under Section 502(a)(3). In an earlier unanimous opinion in an unrelated case, the Supreme Court in *Harris Trust and Savings Bank v. Salomon Smith Barney*<sup>139</sup> characterized Section 502(a)(3) as giving rise to a virtually open-ended universe of potential defendants:

[Section] 502(a)(3) admits of no limit (aside from the “appropriate equitable relief” caveat. . .) on the universe of possible defendants. Indeed, § 502(a)(3) makes no mention at all of which parties may be proper defendants—the focus, instead, is on redressing the “*act or practice* which violates any provision of [title I of ERISA].”<sup>140</sup>

If Section 502(a)(3) is theorized as presenting a potentially infinite range of possible defendants and related claims, it is but one small step to the conclusion that the equitable relief offered by Section 502(a)(3) is fraught with the dangers traditionally associated with a judicial slippery slope. If this perception of Section 502(a)(3) is accurate, a single legal standard defining equitable relief becomes intuitively appealing to those Justices who have concerns about potential judicial slippery slope effects. Moreover, if this perception is accurate, a single legal standard – clear guidance – is judicially efficient. But is this perception of Section 502(a)(3) as a potential judicial slippery slope correct? Here, the analytical insights of Professor Eugene Volokh into the mechanisms by which judicial slippery slopes operate suggest that the answer to this crucial threshold question is “no.”

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137. *Id.* at 233.

138. *Id.* at 217 (first emphasis in original; second emphasis added).

139. 530 U.S. 238 (2000).

140. *Id.* at 246 (emphasis in original). This perception apparently is shared by federal jurists at the court of appeals level. See *Heimann v. Nat’l Elevator Ind. Pension Fund*, 187 F.3d 493, 504 (5th Cir. 1999) (“Unlike four of § 502’s six subsections, § 502(a)(3) is not focused on specific areas or types of defendants.”); *Reich v. Cont’l Cas. Co.*, 33 F.3d 754, 757 (7th Cir. 1994) (noting the profound uncertainty created by the vagueness and breadth of “other appropriate relief”).



## 2. *Slippery Slope Mechanisms and Countermeasures*

In his article, *The Mechanisms of the Slippery Slope*,<sup>141</sup> Professor Volokh examines the theoretical mechanisms by which various types of slippery slopes operate in order to better evaluate the risk that a slippery slope effect will occur. Slippery slope theory serves two useful functions. First, it can reveal slippery slopes that “may seem intuitively plausible, but looking closer at the potential mechanisms might persuade us that in this situation none of them is likely to cause slippage.”<sup>142</sup> Second, a better understanding of the mechanisms of slippery slopes can help to craft effective countermeasures.<sup>143</sup>

Professor Volokh defines a slippery slope as a situation “where decision A, which you might find appealing, ends up materially increasing the probability that others will bring about decision B, which you oppose.”<sup>144</sup> A simple thought experiment puts flesh on this abstract concept and places it in the concrete context of my topic, namely Section 502(a)(3) of ERISA. Assume that “Decision A” involves a case of breach of fiduciary duty under ERISA. Decision A would be a monetary award measured by the make-whole relief standard under the common law of trusts (Professor Langbein’s proposed interpretation of equitable relief).<sup>145</sup> Decision A would result in an award of money sufficient to compensate fully a plan participant who was injured by the fiduciary’s breach of duty under ERISA. You are a Supreme Court Justice, and you find Decision A appealing because Decision A is consistent with ERISA’s purpose of regulating fiduciary conduct so as to safeguard the rights of plan participants.

But you are also aware of another case, currently being litigated in the lower federal courts, where the defendant is a plan service provider who is not an ERISA fiduciary with respect to the plan, but who provides services to a defined benefit pension plan and the plan’s fiduciary administrator. This second case represents “Decision B.” The allegation in the Decision B case is that the plan service provider assisted the plan fiduciary in committing a breach of fiduciary duty by submitting false actuarial funding reports concerning the pension plan’s assets to the Pension Benefit Guaranty Corporation. These false reports enabled the employer to underfund the plan. When the employer became insolvent, the assets in the plan were insufficient to pay the retirement benefits promised to the plan participants. The

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141. Volokh, *supra* note 130, at 1026.

142. *Id.* at 1128.

143. *Id.* at 1128, 1131–32.

144. *Id.* at 1030.

145. See discussion *supra* Part II.B.

relief sought by the plaintiffs in the Decision B case under Section 502(a)(3) is a monetary award sufficient to restore the funding of the employer's retirement plan to the level actuarially required to pay the plan's promised benefits.<sup>146</sup>

As a Supreme Court Justice, you favor Decision A (a make-whole monetary award to the participant who has been injured by a fiduciary's breach of duty), but you are opposed to Decision B (a monetary award against a nonfiduciary plan service provider in an amount sufficient to restore the plan's funding level). You might oppose applying the remedies precedent in Decision A to Decision B because you believe that requiring a defendant who is not an ERISA fiduciary to fulfill the employer's statutory obligation to adequately fund the plan would cause plan service providers to charge employers more for their services to cover the costs associated with this liability risk. Or, you might believe that the statutory language and structure of ERISA does not support financial liability against a party who is not an ERISA fiduciary.<sup>147</sup> What are the slippery slope mechanisms by which Decision A, which you favor, could lead to Decision B, which you oppose? In other words, how realistic are your concerns about the risk of a judicial slippery slope?

Professor Volokh identifies two separate but interrelated mechanisms associated with a judicial slippery slope. These mechanisms are the *legal effect slippery slope* and the *equality/administrative cost slippery slope*. A legal effect slippery slope occurs by force of legal precedent where Decision A rests on some justification (J), and justification J also justifies Decision B.<sup>148</sup> In a legal effect slippery slope situation, the perceived danger is created by an overly broad or vague justification J.<sup>149</sup> An equality/administrative effect slippery slope occurs when a judge feels impelled to extend Decision A to Decision B, either because the two cases seem similar and therefore (the judge believes) should be treated equally, or because the dividing line between Decision A and Decision B is too difficult for other judges to administer and enforce in a consistent manner in subsequent cases.<sup>150</sup> In the equality/administrative cost slippery slope situation, the perceived danger is that other lower federal judges (or your fellow Supreme Court Justices) may have a different understanding of "equality" among cases, or may not be able easily

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146. My description of Decision B is, of course, a simplified summary of the actual facts in *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993).

147. In fact, both of these rationales were given in support of the majority's decision in *Mertens*. See 508 U.S. at 253–55, 262–63.

148. See Volokh, *supra* note 130, at 1064.

149. See *id.* at 1065–66.

150. See *id.* at 1064–71.

to administer a more complex rule. In either instance, the perceived danger is that in a subsequent case Decision A (awarding a monetary relief measured by standard that makes the plaintiff-participant “whole”) may later be broadened and applied to justify a similar monetary award in Decision B.<sup>151</sup>

One countermeasure to a legal effect slippery slope is to rest Decision A on the most narrow justification J possible so that justification J cannot be applied to Decision B.<sup>152</sup> Using my example, justification J for Decision A could be based on the status of the defendant and the nature of the claim under ERISA. In my example, the defendant in Decision A is a fiduciary under ERISA,<sup>153</sup> and the claim is one for breach of fiduciary duty.<sup>154</sup> But this countermeasure does not necessarily resolve the potential risk of an equality/administrative cost slippery slope. As Professor Volokh explains, the mere fact that “a distinction between A and B *can* be drawn doesn’t mean that enough future judges will be persuaded by this distinction.”<sup>155</sup>

One approach to the perceived problem of an equality/administrative cost slippery slope is to eliminate the slippery slope risk entirely by awarding a remedy in Decision A that is also acceptable in the Decision B situation. I call this the “one-size-fits-all” approach to interpretation of the remedies available under Section 502(a)(3). Professor Volokh describes this approach as “not mak[ing] a sound decision today, for fear of having to draw a sound distinction tomorrow.”<sup>156</sup>

My hypothetical one-size-fits-all approach is, of course, the Supreme Court’s current law-equity paradigm. Superficially, the one-size-fits-all approach appears to be a sensible solution to the perceived risks associated with a judicial slippery slope. ERISA is, after all, a federal statute well-known for its daunting complexity.

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151. *See id.* at 1071.

152. *See id.* at 1066.

153. *See* 29 U.S.C. § 1002(21)(A) (2000) (defining a fiduciary).

154. *See* 29 U.S.C. § 1104(a) (2000) defining the duties of a fiduciary with respect to a plan).

155. Volokh, *supra* note 130, at 1066–67. In *Reich v. Continental Casualty Co.*, Judge Richard Posner deftly expressed why other federal judges might find Decision A persuasive authority for Decision B:

In areas of profound uncertainty, such as whether a statute that does not explicitly impose duties on nonfiduciaries should be interpreted as doing so implicitly because of the background of trust law against which it was enacted and the vagueness and breadth of “other appropriate relief” with no specified limitation as to whom the relief can be sought from, federal law is for all practical purposes what the Supreme Court says it is.

*Reich v. Continental Cas. Co.*, 33 F.3d 754, 757 (7th Cir. 1994) (emphasis added).

156. Volokh, *supra* note 130, at 1030.

Because the types of cases that may be brought under Section 502(a)(3) are not limited to my two hypothetical “Decision A versus Decision B” choices,<sup>157</sup> the concern that federal judges may not be able to distinguish between different types of cases and administer a more complex rule is a legitimate one. When this complexity is combined with the judicial perception that an unlimited number of cases may be brought under Section 502(a)(3), one can easily leap to the conclusion that anything other than a single standard (the law-equity paradigm) for determining equitable relief administratively is unworkable.

Again, Professor Volokh’s theory of how slippery slope mechanisms operate is instructive. Professor Volokh theorizes that bounded rationality leads individuals, including federal judges, to simplify a complex body of law by focusing on a few general principles and forgetting the details,<sup>158</sup> or by boiling a decision down into “a brief and not fully accurate summary.”<sup>159</sup> The aftermath of the Supreme Court’s decision in *Mertens* provides a concrete example of this phenomenon of bounded rationality in the context of Section 502(a)(3). In the wake of *Mertens*, the lower federal courts consistently summarized the *Mertens* decision as based on a single justification – that equitable relief is limited to “injunction, mandamus, and restitution”<sup>160</sup> – and applied this justification to all types of cases under Section 502(a)(3).<sup>161</sup> This occurred even though the types of defendants and the nature of the claims brought in these subsequent cases were very different

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157. See discussion *supra* Part II.A and *infra* Part III.

158. See Volokh, *supra* note 130, at 1090–97.

159. *Id.* at 1090.

160. *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256 (1993). One notable exception to this trend is *Strom v. Goldman, Sachs & Co.*, 202 F.3d 138 (2d Cir. 1999), where Judge Kaplan concluded that make-whole relief for economic loss directly caused by the plan fiduciary’s duty was an appropriate equitable remedy under Section 502(a)(3). See *id.* at 150.

161. See *Farr v. U.S. West Communications*, 151 F.3d 908, 915 (9th Cir. 1998) (stating that fiduciary breached duty by providing inadequate and misleading information to participants concerning tax consequences of early retirement package); *Allinder v. Inter-City Prods.*, 152 F.3d 544, 547–52 (6th Cir. 1998) (stating that plan administrator was plainly wrong in refusing to complete paperwork necessary for plaintiff to receive long-term disability plan benefits); *FMC Medical Plan v. Owens*, 122 F.3d 1258, 1260–62 (9th Cir. 1997) (concerning a contractual reimbursement claim brought by plan administrator against participant); *Metropolitan Life Ins. Co. v. Socia*, 16 F. Supp. 2d 66, 72–73 (D. Mass. 1998) (concerning a suit by plan administrator to recover disability plan payments paid to participant).

from the claim in *Mertens*,<sup>162</sup> and the results often seemed harsh rather than equitable.<sup>163</sup>

One solution to my “Decision A versus Decision B” thought experiment would be for the Supreme Court to adopt Professor Langbein’s proposed make-whole relief standard for monetary awards as an exception for breach of fiduciary duty cases brought under Section 502(a)(3), while retaining the law-equity paradigm of *Mertens* and *Great-West* as the “general rule” governing all other types of cases brought under Section 502(a)(3). Professor Volokh’s theory suggests why this solution is unlikely to appeal to those Justices who are concerned about the potential judicial slippery slope effects of Section 502(a)(3). According to Professor Volokh, the phenomenon of bounded rationality means that when looking at a

broader body of law, people are especially unlikely to precisely absorb all the details of each past case. . . ; instead, they tend to try to fit the decisions into a general mold that stresses one or two basic principles at the expense of many of the details. . . . One classic example of such a general mold is “This is the rule, though there are some exceptions”. . . . But at some point, some people who are surveying the body of decisions may start concluding that the law is so internally inconsistent [due to its burgeoning exceptions] that they can’t distill any core underlying principles from it, or even that the exceptions themselves have become the rule.<sup>164</sup>

Thus, urging the Supreme Court to adopt Professor Langbein’s proposal for fiduciary duty cases as an “exception” to the “general rule” of *Mertens* and *Great-West* is unlikely to persuade those Justices who are concerned about judicial slippery slope effects. It is foreseeable that one “exception” may lead to a second, and then to a third, and then ultimately to the erosion of the “general rule.” This erosion risk is particularly acute in light of the broad universe of claims that fall within the breach of fiduciary duty category under ERISA<sup>165</sup> and the fact that breach of fiduciary claims are often intertwined with other types of claims under Section 502(a)(3).<sup>166</sup>

Professor Volokh further suggests why, despite the

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162. See *Farr*, 151 F.3d at 915–16 (refusing to apply “appropriate equitable relief” as a different standard for fiduciary versus nonfiduciary); *McLeod v. Oregon Lithoprint, Inc.*, 102 F.3d 376, 378 (9th Cir. 1996) (ignoring fiduciary versus nonfiduciary distinction under *Mertens*); *Armstrong v. Jefferson Smurfit Corp.*, 30 F.3d 11, 13 (1st Cir. 1994) (holding that status of defendant as fiduciary versus nonfiduciary is irrelevant under *Mertens* when determining appropriate equitable relief for alleged breach of fiduciary duty under Section 502(a)(3)).

163. See *supra* note 108 and accompanying text.

164. Volokh, *supra* note 130, at 1093–94 (emphasis added).

165. See discussion *infra* Parts III.C.3.c.i.-vi.

166. See discussion *infra* Appendix B.

paradoxical results produced, those Supreme Court Justices who are concerned about the potential judicial slippery slope effects of Section 502(a)(3) nevertheless may be reluctant to jettison the law-equity paradigm as the underlying theory for judicial interpretation of equitable relief. Volokh identifies this phenomenon as the *judicial-judicial attitude altering slippery slope*.<sup>167</sup> The judicial-judicial attitude altering slippery slope derives from the judicial attitude that the general principles that underlie prior precedents are presumptively morally or empirically sound.<sup>168</sup> Professor Volokh posits that lower federal court judges may be so deferential to the general principle that underlies a “new” precedent that they will apply this general principle to other situations where, strictly speaking, the “new” precedent is not binding.<sup>169</sup> This is, in fact, precisely what happened in the wake of the Supreme Court’s decision in *Mertens*.<sup>170</sup> Professor Volokh argues that to mitigate this potential risk, “various [Supreme Court] Justices have refused to adopt new principles that lack well-defined, coherent limits.”<sup>171</sup>

The perceived risk of a judicial-judicial attitude altering slippery slope may further discourage some Supreme Court Justices from adopting Professor Langbein’s proposal. Merely substituting the principle of make-whole relief under the common law of trusts for the Supreme Court’s law-equity paradigm may not create the “well-defined, coherent limits” that would curtail the perceived judicial slippery slope risks presented by Section 502(a)(3).<sup>172</sup>

### 3. A “Fresh Start” for Section 502(a)(3)

Thus far, slippery slope theory seems to justify the retention of the law-equity paradigm (a clear rule) as the governing doctrinal theory for interpretation of equitable relief available under Section 502(a)(3). Slippery slope theory further suggests why the Supreme Court may be reluctant to recognize make-whole relief as an available remedy for breach of fiduciary duty claims brought under Section 502(a)(3). But what if the perception of Section 502(a)(3) as a potential judicial slippery slope is false? What if, contrary to the Supreme Court’s statement in *Harris Trust and Savings Bank v. Salomon Smith Barney, Inc.*,<sup>173</sup> the

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167. Volokh, *supra* note 130, at 1098–1100.

168. *Id.* at 1098.

169. *Id.* at 1098–99.

170. See Meltzer, *supra* note 100, at 346 & n.2.

171. Volokh, *supra* note 130, at 1099.

172. For example, should the theory of make-whole relief apply to claims against nonfiduciaries who assist in a fiduciary’s breach of duty? See discussion *supra* note 155.

173. 530 U.S. 238 (2000).

universe of defendants and related claims under Section 502(a)(3) is *not* unlimited? What if Section 502(a)(3) can be conceptualized as encompassing a finite number of easily recognizable and readily distinguishable categories of defendants and related claims? Or, in other words, what if Section 502(a)(3), *when viewed in the context of the entire statutory framework of title I of ERISA*, is not a “slope” at all, but rather is a series of well-delineated “boxes” instead?

The central thesis of this Article, presented in Part III, is that careful statutory analysis of the entirety of title I of ERISA reveals there are six distinct categories of defendants and related claims that are possible under Section 502(a)(3). These six categories are derived from the statutory definitions and statutory provisions of title I of ERISA. Because these six categories are uniquely distinct, they serve as bulwarks against the risks of a judicial slippery slope.

Once Section 502(a)(3) is conceptualized as consisting of six distinct categories of defendants and related claims, it becomes possible for the Supreme Court to resolve the judicial paradox of ERISA remedies. Rather than continuing to rely on the flawed law-equity paradigm to define equitable relief under Section 502(a)(3), the Supreme Court instead may look to the policy objective or mix of policy objectives that underlie each category of claims to determine “*appropriate equitable relief*.”

The kernel of my central thesis is not new. After *Mertens*, the Department of Labor vigorously advocated that the status of the defendant as fiduciary or non-fiduciary should affect the nature of equitable relief available under Section 502(a)(3).<sup>174</sup> The Department of Labor’s position in these cases is similar to the argument made by Professor Langbein, namely that the federal courts should look to the common law of trusts and award monetary relief when the claim under Section 502(a)(3) is brought against a fiduciary for a breach of fiduciary duty.<sup>175</sup> To date, the

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174. See *Callery v. U.S. Life Ins. Co.*, 392 F.3d 401, 409 (10th Cir. 2004) (“[O]ther courts have rejected the distinction...based on the status of the defendant as a fiduciary.”); *McLeod v. Oregon Lithoprint*, 102 F.3d 376, 378 (9th Cir. 1996) (“[T]he status of the defendant, whether fiduciary or nonfiduciary, does not affect the question of whether damages constitute ‘appropriate equitable relief’ under § 502(a)(3).” (citing *Armstrong v. Jefferson Smurfit Corp.*, 30 F.3d 11, 13 (1st Cir. 1994))).

175. Most recently, this position was reasserted by the Department of Labor in its *amicus curia* brief in *Aetna Health Inc. v. Davila*. 542 U.S. 200, 223–24 (2004) (Ginsburg, J., concurring). See also *Callery*, 392 F.3d at 408 (“[A]mici Secretary of Labor...assert[s] that the limited availability of monetary damages in *Mertens* and *Great-West* is inapplicable in this case because those cases involved contract breaches by non-fiduciaries, rather than a claim against a fiduciary for a breach of fiduciary duty.”). See generally *Rego v. Westvaco Corp.*, 319 F.3d 140, 144–46 (4th Cir. 2003); *Crosby v. Bowater, Inc.* Ret. Plan, 382 F.3d 587, 596 (6th Cir. 2004); *Helfrich v. PNC Bank, Inc.*, 267

lower federal courts have consistently rejected this argument as foreclosed by *Mertens* and *Great-West*.<sup>176</sup> The Supreme Court has not spoken definitively on this issue.<sup>177</sup> Thus, the door remains open for the Supreme Court to reassess the utility of the law-equity paradigm and instead adopt a fresh start for judicial interpretation of Section 502(a)(3). Part III of the Article presents the statutory and policy analysis for why the Department of Labor's proposed interpretation of Section 502(a)(3) – that the status of the defendant and the nature of the claim *is* relevant to the determination of “appropriate equitable relief” available – is on sound (rather than slippery) footing as a matter of doctrinal theory.

In considering the possibility of a fresh start for Section 502(a)(3), the Supreme Court's recent experience with interpretation of another difficult ERISA provision, preemption of state law under Section 514(a),<sup>178</sup> is encouraging.<sup>179</sup> Section 514(a) generally provides for preemption of all state laws that “relate to” an employee benefit plan.<sup>180</sup> After struggling for many years with attempting to define this opaque phrase, the Supreme Court in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*<sup>181</sup> finally admitted that “our prior attempt to construe the phrase ‘relate to’ does not give us much help,”<sup>182</sup> and decided to “go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide. . . .”<sup>183</sup>

Section 502(a)(3), like Section 514(a), suffers from similarly unhelpful drafting of the statutory text. To date, when interpreting Section 502(a)(3) the Supreme Court has looked primarily *outside* of the statute, and has seized upon “an ancient classification unrelated to the substance of the relief sought”<sup>184</sup> for

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F.3d 477, 482–83; *Kerr v. Charles F. Vatterott & Co.*, 184 F.3d 938, 945 (8th Cir. 1999); *Rogers v. Hartford Life & Accident Ins. Co.*, 167 F.3d 933, 944 (5th Cir. 1999); *McLeod*, 102 F.3d at 378; *Armstrong*, 30 F.3d at 13.

176. See *Callery*, 392 F.3d at 409 (“While the arguments of amici that we should look to the common law of trusts and award monetary damages pursuant to an equitable breach of trust by a fiduciary may have been compelling before *Great-West*, they are not so now.”); *Crosby*, 382 F.3d at 596 (stating that the argument that money damages should be awarded in a suit against a fiduciary is “explicitly rejected” by *Great-West*).

177. See discussion *infra* Part III.D.4.

178. 29 U.S.C. § 1144(a) (2000).

179. See Langbein, *supra* note 13, at 1331–32; *Cicio v. Does*, 321 F.3d 83, 107 & n.1 (2d Cir. 2003) (Calabresi, J., dissenting).

180. 29 U.S.C. § 1144(a).

181. 514 U.S. 645 (1995).

182. *Id.* at 655.

183. *Id.* at 656.

184. *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 224 (2002) (Ginsburg, J., dissenting).



interpretive guidance. The results, as demonstrated by the cases described in Part II of the Article, have proven unsatisfactory.

Rather than continuing to draw ever finer distinctions between remedies available at law and in equity,<sup>185</sup> this Article proposes that the Supreme Court should modify its approach to Section 502(a)(3) by looking first *inside* the provisions of title I of ERISA to ascertain how Section 502(a)(3) functions within the context of the overall statutory scheme to facilitate and serve ERISA's various policy objectives.<sup>186</sup> This foundation of statutory structure and closely related policy objectives, instead of a "rigid and time-bound conception of the term 'equity,'"<sup>187</sup> should determine what constitutes "appropriate equitable relief" for claims brought under Section 502(a)(3). Part III of the Article develops this fresh judicial approach to interpretation of Section 502(a)(3).

### III. A STATUTORY AND POLICY-BASED THEORY FOR JUDICIAL INTERPRETATION OF SECTION 502(A)(3) CLAIMS AND REMEDIES

Section 502(a)(3) has proven troublesome for the federal courts because the statutory language on its face appears to be ambiguous. Rather than identifying particular types of defendants and related claims, Section 502(a)(3) is written in an open-ended fashion. Section 502(a)(3) states:

A civil action may be brought by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of [title I of ERISA] or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of [title I of ERISA].<sup>188</sup>

In failing to identify the universe of possible defendants and related claims, Section 502(a)(3) essentially creates a logic puzzle. Three types of potential *plaintiffs* - participants, beneficiaries, and fiduciaries - are expressly identified by the statute. The types of *defendants*, and the *claims* that plaintiffs may bring against them, are not. This leads to two questions: What types of claims, against what types of defendants, are permitted for these plaintiffs? What forms of "equitable" relief are "appropriate" remedies for these claims?

When faced with a seemingly open universe of possible

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185. See *id.* at 214 ("Admittedly, our cases have not previously drawn this fine distinction between restitution at law and restitution in equity. . .").

186. Cf. ANTONIN SCALIA, A MATTER OF INTERPRETATION 143-44 (1997) ("The more episodic and oblivious of adjacent law modern legislation becomes, the more crucial is the judicial function of *making sense out of the whole*, which can be achieved in principled fashion only through the application of legitimate interpretive techniques." (emphasis added)).

187. *Great-West*, 534 U.S. at 224 (Ginsburg, J., dissenting).

188. 29 U.S.C. § 1132(a)(3) (2000).

defendants, related claims, and potential remedies, one useful analytical technique made famous by Guido Calabresi and A. Douglas Melamed is to model the universe of possible outcomes.<sup>189</sup> There is, of course, a significant distinction between the Calabresi and Melamed model and the modeling exercise presented in this Article. Calabresi and Melamed examined common law rules, whereas this model examines a statutory set of rules. Despite this difference, I believe that the modeling technique presented in the Article is consistent with the spirit of the Calabresi and Melamed modeling technique, which aims to develop a doctrinal theory that ties together and makes sense of a seemingly disjointed body of law as a whole, and in the process identify claims that theoretically are possible but that have not yet appeared before the courts.

Part III of the Article summarizes the results of a modeling exercise I conducted using a three stage analysis. The foundation for the modeling exercise is ERISA's statutory structure. The statutory definitions and the interrelationships among ERISA's statutory provisions reveal that the statute has its own internally consistent logic. It is this internal logic that drives the modeling exercise, and ultimately produces a doctrinal theory grounded in the statute as a whole. In short, the "answer" to the logic puzzle of Section 502(a)(3) lies in the role that Section 502(a)(3) plays within the context of title I of ERISA.

The first order analysis of the modeling exercise, described in Part III.A, deduced the universe of possible defendants. The result of the first order analysis was a plaintiff-defendant matrix. The second order analysis, described in Part III.B., focused on the most problematic aspect of the statutory language of Section 502(a)(3), namely defining the universe of possible claims. The second order analysis examined all of the statutory provisions of title I of ERISA and grouped these statutory provisions by their common characteristics. This process condensed the statutory provisions of title I of ERISA to four groups of possible claims. Claims alleging a violation of plan terms (a type of claim expressly authorized by the text of Section 502(a)(3)<sup>190</sup>) formed a fifth group of possible claims.

The product of the first and second order analysis of the modeling exercise was a plaintiff-defendant-claim matrix with sixty possible combinations. The third order analysis, described in Part III.C., consolidated these sixty combinations to determine the universe of categories of defendants and related claims that are possible under Section 502(a)(3). The outcome of the modeling exercise was six distinct categories of defendants and related

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189. See Calabresi & Melamed, *supra* note 17, at 1089-1115.

190. See 29 U.S.C. § 1132(a)(3).

claims that form the universe of private civil actions that are possible under Section 502(a)(3). The six categories are summarized below.

THE SIX CATEGORIES OF DEFENDANTS AND RELATED CLAIMS

<u>CATEGORY</u>	<u>PLAINTIFF(S)</u>	<u>DEFENDANT</u>	<u>CLAIM</u>
I	Participants/ Fiduciaries	Employee Benefit Plan	Plan Design Requirements
II	Participants/ Fiduciaries	Employers	Retaliation, Improper Amendment Procedures, or Inurement of Plan Assets
III	Participants/ Fiduciaries	Fiduciaries	Breach of Fiduciary Responsibilities (Including Wrongfully Denied Benefits)
IV	Participants/ Fiduciaries	Participants	Violation of Plan Terms
V	Participants/ Fiduciaries	Parties In Interest (Nonfiduciary)	Knowing Participation In Breach of Fiduciary Duties Or Engaging In Prohibited Transactions
VI	Participants/ Fiduciaries	Third Parties	Knowing Participation In Breach of Fiduciary Duties, Engaging In Prohibited Transactions, or Participation in Violation of Plan Terms

Part III.C. provides illustrations of the six categories of defendants and related claims and describes the subtypes of claims that exist in some of the categories. Using the results of the modeling exercise, Part III.D. proposes a new interpretive approach, the *ERISA Policy Triangle*, to the determination of “appropriate equitable relief” under Section 502(a)(3) based on the six categories of defendants and the related claims.

*A. First Order Analysis: Identifying the Plaintiff-Defendant Matrix*

*1. The First Limiting Parameter: Using Statutory Status to Identify the Universe of Plaintiffs and Defendants*

ERISA defines and regulates the conduct of persons<sup>191</sup> based upon their relationship to an employee benefit plan.<sup>192</sup> As a general rule, the statutory provisions of title I of ERISA expressly regulate only persons who have a certain status, a specific type of relationship to a plan that is recognized and defined by the statute.<sup>193</sup>

This relationship-based statutory construct formed the starting point for the modeling exercise. ERISA’s statutory definitions operate to limit those persons who are subject to the system of regulation created under title I of ERISA. Based on this insight, the first order analysis of the modeling exercise used the

191. ERISA defines a “person” as “an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization.” 29 U.S.C. § 1002(9) (2000). I use the same definition throughout the Article.

192. See 29 U.S.C. § 1021 (2000) (regulating plan administrators and employers who sponsor plans); 29 U.S.C. § 1024 (2000) (regulating plan administrators); 29 U.S.C. § 1059 (2000) (regulating employers who sponsor pension plans and plan administrators); 29 U.S.C. § 1103(c)(1) (2000) (regulating employers who sponsor plans); 29 U.S.C. § 1104(a), (b), (d) (2000) (regulating plan fiduciaries); 29 U.S.C. § 1105(a) (2000) (regulating plan fiduciaries); 29 U.S.C. § 1105(b) (regulating plan trustees); 29 U.S.C. § 1106 (2000) (regulating plan fiduciaries and parties in interest); 29 U.S.C. § 1109–11 (2000) (regulating plan fiduciaries); 29 U.S.C. § 1112 (2000) (regulating plan fiduciaries and plan officials); 29 U.S.C. § 1161 (2000) (regulating sponsors of group health plans); 29 U.S.C. § 1166(a) (2000) (regulating employers who sponsor group health plans, plan participants, and plan administrators).

193. See statutes cited *supra* note 192. Section 502(l), 29 U.S.C. § 1132(l) (2000), which allows the Secretary of Labor to penalize virtually any “person” who knowingly participates in a fiduciary’s breach of duty, or who engages in a prohibited transaction, represents the sole exception to this general rule. See discussion *infra* Parts III.C.3.e-f.

statutory definitions found in Section 3 of ERISA<sup>194</sup> ("Section 3") as a limiting parameter for determining the universe of potential defendants.

## 2. *The Plaintiff-Defendant Matrix*

Section 502(a)(3) expressly is limited to three types of plaintiffs: (1) participants;<sup>195</sup> (2) beneficiaries;<sup>196</sup> and (3) fiduciaries.<sup>197</sup> To simplify the universe of potential plaintiffs under Section 502(a)(3), I combined participants and beneficiaries into a single group of possible plaintiffs (hereinafter collectively referred to as "participants") because these two groups are functionally analogous.<sup>198</sup> The two types of possible plaintiffs identified by Section 502(a)(3) — participants and fiduciaries — formed the first column of the plaintiff-defendant matrix.

The second column of the plaintiff-defendant matrix consisted of six types of possible defendants. Participants (again, defined to include beneficiaries) and fiduciaries are both distinct status groups recognized by title I of ERISA through the definitions in Section 3. Therefore, these two groups also were included as possible defendants. A third type of possible defendant recognized

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194. 29 U.S.C. § 1002 (2000).

195. ERISA defines a "participant" as:

[A]ny employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

29 U.S.C. § 1002(7).

196. ERISA defines a "beneficiary" as "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." 29 U.S.C. § 1002(8).

197. ERISA defines a fiduciary in functional terms based upon the person's relationship with the plan. The statutory language states:

a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

29 U.S.C. § 1002(21)(A). In addition, ERISA requires that the written document establishing the plan must "provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan." 29 U.S.C. § 1102(a)(1) (2000).

198. ERISA defines both participants and beneficiaries as individuals who are or may become eligible to receive a benefit from the plan. Compare 29 U.S.C. § 1002(8) with 29 U.S.C. § 1002(9).

by title I of ERISA is the employee benefit plan itself.<sup>199</sup> Employers<sup>200</sup> and employee organizations (primarily labor unions)<sup>201</sup> formed a fourth type of possible defendant. Because employers and employee organizations often are functionally analogous in their role as plan sponsors,<sup>202</sup> to simplify the universe of potential defendants under Section 502(a)(3), I combined employers and employee organizations into a single group of possible defendants (hereinafter collectively referred to as “employers”).

Parties in interest<sup>203</sup> formed a fifth type of possible defendant. ERISA’s definition of a party in interest is very broad, and includes a fiduciary,<sup>204</sup> the employer who sponsors the plan,<sup>205</sup> and any employee of the employer who sponsors the plan.<sup>206</sup> To avoid overlapping categories of defendants, I used the term “party in interest” to refer to all persons who satisfied the statutory definition of a party in interest under Section 3(14), *excluding* any person who also qualified as a fiduciary, the plan’s sponsoring employer, or as an employee who was a plan participant. This

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199. ERISA provides that “[a]n employee benefit plan may sue or be sued under [title I] as an entity.” 29 U.S.C. § 1132(d)(1) (2000). Money judgments obtained against an employee benefit plan are enforceable against the plan as an entity. 29 U.S.C. § 1132(d)(2). Such money judgments are not enforceable against other persons associated with the plan (e.g., a plan fiduciary), unless liability under ERISA has been separately established against such person. *Id.*

200. ERISA defines an employer as “any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.” 29 U.S.C. § 1002(5) (2000). Because the provisions of title I of ERISA that are enforceable through Section 502(a)(3) apply to both single-employer plans, *see* 29 U.S.C. § 1002(41), and multi-employer plans, *see* 29 U.S.C. § 1002(37)(A), for purposes of simplicity the modeling exercise did not distinguish between these two types of plans.

201. ERISA defines an employee organization as

any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships; or any employees’ beneficiary association organized for the purpose in whole or in part, of establishing such a plan.

29 U.S.C. § 1002(4).

202. *See* 29 U.S.C. § 1003(a)(1)-(3) (2000) (stating that title I of ERISA “shall apply to any employee benefit plan if it is established or maintained—by any employer. . .[.] by any employee organization. . .[., or] by both.”)

203. ERISA defines a party in interest based on the person’s relationship with the plan itself, or with the employer who sponsors the plan. The statutory definition is quite complex. *See* 29 U.S.C. § 1002(14) (2000) (defining party in interest).

204. 29 U.S.C. § 1002(14)(A).

205. 29 U.S.C. §§ 1002(14)(C)-(D).

206. 29 U.S.C. § 1002(14)(H).

approach meant that the typical party in interest defendant in the modeling exercise was a plan service provider who provided professional services in a nonfiduciary capacity, such as actuarial, record keeping, ministerial claim processing, brokerage, or legal services for a plan.

Persons who did not fit into any of the five types of possible defendants described above were assigned to a residual sixth group of possible defendants. I designated this residual sixth group as “third parties” because these defendants do not have a relationship with an employee benefit plan that is expressly recognized by the statutory definitions of Section 3. Although a group of defendants consisting of “everyone else” seemed disconcerting at first, in the context of actual ERISA litigation this group of defendants appeared to be quite small. Third party defendants are third party defendants precisely because they do not have a direct connection or relationship with an employee plan. Rather, as demonstrated later in Part III of the Article, a third party defendant becomes involved in a claim under Section 502(a)(3) as the result of his or her relationship or transaction with a person who is a fiduciary, party in-interest, or a participant with respect to a plan.<sup>207</sup>

The result of the first order analysis was a two-column, two by six matrix, presented in Table 1 below.

TABLE 1  
THE PLAINTIFF-DEFENDANT MATRIX

<u>PLAINTIFF</u>	<u>DEFENDANT</u>
1. Participants	1. Employee Benefit Plan
2. Fiduciaries	2. Employers
	3. Fiduciaries
	4. Participants
	5. Parties In Interest
	6. Third Parties

*B. Second Order Analysis: Identifying Groups of Claims Based on Common Characteristics*

The first order analysis of the modeling exercise determined a finite number of plaintiffs and possible defendants using the statutory definitions in Section 3 of ERISA. The second order analysis reduced the seemingly unlimited universe of possible claims under Section 502(a)(3) – any violation of title I of ERISA or of plan terms – into a finite number of groups of possible claims.

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207. See discussion *infra* Part III.C.3.f.

Accomplishing this task required a comprehensive review of all of the statutory provisions of title I of ERISA.<sup>208</sup>

The second order analysis focused on identifying common characteristics among the various statutory provisions of title I of ERISA. This common characteristic analysis revealed that the statutory provisions of title I consist of four groups of possible claims. I added to these four groups of statutory claims a fifth group of claims based on the common characteristic that the plaintiff's claim asserts on a violation of the terms of an employee benefit plan. This fifth group of claims derives from the statutory language of Section 502(a)(3), which expressly authorizes claims to enforce the terms of a plan.<sup>209</sup> The five groups of possible claims under Section 502(a)(3) produced by the second order analysis of the modeling exercise are summarized in Table 2.

TABLE 2  
THE UNIVERSE OF POSSIBLE CLAIMS UNDER SECTION 502(A)(3)

1. Violation of Statutory Plan Design Requirements
2. Retaliation Against Participants, Improper Plan Amendment Procedures, or Inurement of Plan Assets
3. Breach of Fiduciary Responsibilities (Including Wrongfully Denied Benefits)
4. Prohibited Transactions
5. Violation of Plan Terms

The common characteristics that determined the five groupings of possible claims under Section 502(a)(3) are explained below.

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208. Title I of ERISA is divided into seven parts. *See* 29 U.S.C. §§ 1021–1031 (2000) (establishing reporting and disclosure requirements for sponsors of employee benefit plans); 29 U.S.C. §§ 1051–1061 (2000) (establishing minimum participation and vesting requirements for employee pension benefit plans); 29 U.S.C. §§ 1081–1086 (2000) (setting out minimum funding requirements for sponsors of certain types of employee pension benefit plans); 29 U.S.C. §§ 1101–1114 (2000) (containing ERISA's fiduciary duty provisions and prohibited transaction rules); 29 U.S.C. §§ 1131–1147 (2000) (governing civil enforcement, administrative procedures, and preemption of state law); 29 U.S.C. §§ 1161–1169 (2000) (requiring group health plans to offer continued coverage to plan participants under specified circumstances); 29 U.S.C. §§ 1181–1185b (2000) (establishing requirements for group health plans concerning participants' eligibility and pre-existing condition exclusionary periods, maternity benefits, mental health benefits, and breast-cancer-related benefits). In reviewing the statutory provisions of title I of ERISA, I organized the task by focusing on each of these seven parts and then reviewing the statutory provisions within each part.

209. 29 U.S.C. §1132(a)(3) (2000).



### 1. *Violation of Statutory Plan Design Requirements*

ERISA regulates pension and health care plans through statutory standards for plan design.<sup>210</sup> Group 1 claims share the common characteristic that the claim relates to a violation of one of these statutory standards for plan design. ERISA does not authorize an independent civil cause of action against the employer who sponsors the plan for a violation of these statutory plan design standards.<sup>211</sup> Rather, these statutory standards governing plan design can only be enforced as a claim brought under Section 502(a)(3) based on a violation of a statutory provision of title I of ERISA.

### 2. *Retaliation Against Participants, Improper Plan Amendment Procedures, or Inurement of Plan Assets*

Group 2 claims represent violations of ERISA that involve either a retaliatory employment action under Section 510,<sup>212</sup> a failure to follow the procedures for a plan amendment that are described in the plan document pursuant to Section 402(b)(3),<sup>213</sup> or the inurement of plan assets to the benefit of the employer in violation of Section 403(c)(1).<sup>214</sup> The common characteristic among Group 2 claims is that these provisions regulate the conduct of the employer when the employer is *not* acting as a fiduciary. It is this common characteristic that distinguishes Group 2 claims from Group 3 claims, which involve a breach of fiduciary duty by a

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210. See 29 U.S.C. § 1052 (establishing minimum participation standards for pension plans); 29 U.S.C. § 1053 (establishing minimum vesting standards for pension plans); 29 U.S.C. § 1054 (establishing minimum benefit accrual requirements for pension plans and restrictions on pension plan amendments); 29 U.S.C. § 1055 (establishing joint and survivor and pre-retirement survivor annuity requirements for pension plans); 29 U.S.C. § 1056 (establishing other requirements for the form and payment of benefits from pension plans); 29 U.S.C. § 1058 (establishing restrictions on the merger or consolidation of plans or the transfer of plan assets); 29 U.S.C. § 1082 (establishing minimum funding standards for pension plans); 29 U.S.C. § 1102 (requiring plans to be established by a written instrument that contains specified procedures for funding, allocation of administrative responsibilities, and plan amendments); 29 U.S.C. § 1103 (requiring plan assets to be held in trust); 29 U.S.C. § 1107 (restricting assets a plan may hold); 29 U.S.C. § 1161 (requiring group health plans to offer continuation of coverage under specified conditions); 29 U.S.C. § 1169 (establishing certain other standards for group health plans); 29 U.S.C. § 1181 (establishing limitations on pre-existing condition coverage exclusions for health plans); 29 U.S.C. § 1182 (prohibiting discrimination based on health-status related factors for health plans); 29 U.S.C. § 1183 (regulating multi-employer health plans); 29 U.S.C. § 1185 (establishing minimum benefit standards for mothers and newborns); 29 U.S.C. § 1185a (establishing standards for mental health benefits).

211. See 29 U.S.C. § 1132 (2000).

212. 29 U.S.C. § 1140 (2000).

213. 29 U.S.C. § 1102(b)(3) (2000).

214. 29 U.S.C. § 1103(c)(1) (2000).

person (including an employer) who is acting *as a fiduciary* with respect to the plan.

Section 510 of ERISA protects the rights of plan participants by generally prohibiting interference with those rights (or the future attainment of those rights) through a retaliatory employment action such as termination, discipline, discrimination, or suspension of employment. When an employer makes an employment-related decision concerning personnel, the employer normally is not acting as a fiduciary with respect to the plan.<sup>215</sup> ERISA does not authorize an independent civil cause of action for a violation of Section 510.<sup>216</sup> Section 510 is enforced through a claim brought under Section 502(a)(3).<sup>217</sup>

When an employer amends an ERISA plan, under the settlor function doctrine the employer is not acting as a fiduciary.<sup>218</sup> Therefore, the employer's decision to amend the plan is not subject to a claim of breach of fiduciary duty.<sup>219</sup> Section 402(b)(3) of ERISA ("Section 402(b)(3)") requires that every plan must describe a procedure for amending the plan and for identifying the persons with authority to amend the plan.<sup>220</sup> This statutory provision, which functions as a corollary to the written plan document rule of Section 402(a)(1) of ERISA<sup>221</sup> ("Section 402(a)(1)") requires that the employer must comply with the plan's stated amendment procedures when amending the plan.<sup>222</sup> The "heart" of a claim based on an improper amendment concerns a fact-intensive inquiry into the issue of compliance with the plan's stated amendment procedure.<sup>223</sup>

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215. An exception would be when the employer, acting as the named plan fiduciary, makes employment decisions concerning individuals who are serving as fiduciaries with respect to the plan, such as the decision to discharge a individual who serves as the administrator of the plan.

216. 29 U.S.C. § 1140.

217. See *Ingersoll-Rand Co. v. Mc Clendon*, 498 U.S. 133, 142–44 (1990).

218. See *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 444–45 (1999); *Lockheed Corp. v. Spinks*, 517 U.S. 882, 889–91 (1996); *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) *see also* discussion *infra* Part III.D.1.

219. See *Hughes Aircraft Co.*, 525 U.S. at 444–45 (noting that generally an employer's decision to amend a plan does not implicate the employer's fiduciary duties); *Lockheed Corp.*, 517 U.S. at 889–91 (noting that employers may amend employee plans without being subjected to "fiduciary review"); *Curtiss-Wright Corp.*, 514 U.S. at 78 (explaining that employers do not act in a fiduciary capacity when amending their plans).

220. 29 U.S.C. § 1102(b)(3) (2000).

221. 29 U.S.C. § 1102(a)(1).

222. See *Curtiss-Wright Corp.*, 514 U.S. at 78–81 (outlining the requirements of Section 402(b)(3)).

223. *Id.* at 85.

Section 403(c)(1) of ERISA<sup>224</sup> (“Section 403(c)(1)”) known as the anti-inurement clause, states in relevant part that “the assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purpose of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan.”<sup>225</sup> Section 403(c)(1) is a specific prohibition on conduct by the employer, when acting in its employer capacity rather than as a fiduciary, that involves the assets of the plan. For example, an anti-inurement claim is possible when the employer amends the terms of the plan so that the assets of the plan benefit the employer, and, as a result of the plan amendment, the plan assets are not used for the payment of benefits to plan participants.<sup>226</sup>

ERISA does not authorize an independent civil cause of action for a plan amendment that is improperly enacted, or for the improper inurement of plan assets to the benefit of the employer.<sup>227</sup> Like a violation of Section 510, these statutory requirements must be enforced through a claim brought under Section 502(a)(3) based on a violation of the relevant statutory provision of title I of ERISA.

### 3. *Breach of Fiduciary Duties*

Group 3 claims involve conduct by a fiduciary that violates the fiduciary and co-fiduciary duties listed in Section 404(a)<sup>228</sup> and Section 405<sup>229</sup> of ERISA (“Section 404(a)” and “Section 405,” respectively). Breach of fiduciary duty claims today are the most numerous type of claim, the most significant from a policy perspective, and the most controversial in terms of the remedies available under Section 502(a)(3).

Section 404(a) imposes four primary duties on fiduciaries. These duties are: (1) the duty of loyalty to plan participants (also known as the exclusive benefit rule);<sup>230</sup> (2) the duty of prudence;<sup>231</sup>

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224. 29 U.S.C. § 1103(c)(1) (2000).

225. § 1103(c)(1).

226. *See* Hughes Aircraft Co. v. Jackson, 525 U.S. 432, 441–43 (1999) (concluding that the employer’s amendment changing the benefit amounts paid by the plan did not violate the anti-inurement clause because ultimately the assets remained inside the plan and were eventually used to pay benefits to other plan participants).

227. 29 U.S.C. § 1132(a) (2000).

228. 29 U.S.C. § 1104 (2000).

229. 29 U.S.C. § 1105 (2000).

230. *See* 29 U.S.C. § 1104(a)(1)(A). Group 3 claims for breach of the fiduciary duty of loyalty may overlap with Group 4 claims involving a violation of the prohibited transaction rules of ERISA. Group 4 claims are discussed *infra* Part III.B.4.

231. 29 U.S.C. § 1104(a)(1)(B).

(3) the duty of prudent diversification of plan assets;<sup>232</sup> and (4) the duty to follow the terms of the plan, unless such terms are contrary to a statutory provision of title I of ERISA.<sup>233</sup>

Section 405 imposes duties in certain circumstances on one fiduciary (the “co-fiduciary”) for a breach of fiduciary responsibility by another fiduciary. Under Section 405(a), the co-fiduciary is liable for the other fiduciary’s breach of duty if the co-fiduciary knows, or should know, of the fiduciary’s breach, and either participates in the breach, undertakes to conceal the breach, or fails to take corrective measures.<sup>234</sup> In addition, a co-fiduciary is liable if the co-fiduciary’s own breach of fiduciary duty, such as a failure to prudently monitor the other fiduciary, enables the other fiduciary to commit a breach.<sup>235</sup> Section 405 also contains a separate set of specialized co-fiduciary duty rules for co-trustees<sup>236</sup> and investment managers.<sup>237</sup>

#### 4. Prohibited Transactions

Group 4 claims assert a violation of the prohibited transaction rules of Section 406 of ERISA<sup>238</sup> (“Section 406”). Section 406 creates two sets of prohibited transaction rules. The first set of rules, contained in Section 406(a), applies to persons who are parties in interest.<sup>239</sup> In the first order analysis of the modeling exercise, I defined the category of defendants classified as “parties in interest” to exclude any person who also qualified as a fiduciary, the employer who sponsored the plan, or an employee who was also a plan participant.<sup>240</sup> The second set of rules, found in Section 406(b), apply only to persons who are fiduciaries. To distinguish between these two sets of prohibited transaction rules, in the discussion below I refer to the Section 406(a) rules as *party in interest prohibited transactions*, and to the Section 406(b) rules as *fiduciary prohibited transactions*.

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232. 29 U.S.C. § 1104(a)(1)(C).

233. 29 U.S.C. § 1104(a)(1)(D).

234. 29 U.S.C. § 1105(a)(1), (a)(3).

235. 29 U.S.C. § 1105(a)(2) (2000).

236. 29 U.S.C. § 1105(b).

237. 29 U.S.C. § 1105(d).

238. 29 U.S.C. § 1106 (2000). See *Donovan v. Cunningham*, 716 F.2d 1455, 1464-65 (5th Cir. 1983) (asserting that the prohibited transactions rules of Section 406 are built upon the principle that certain types of transactions involving plan assets should be made illegal *per se* because such transactions historically have entailed a high risk of abuse). Section 406(a)(5), 29 U.S.C. § 1106(a)(5), incorporates by reference the limitations of Section 407 on employer securities or employer real property held as plan assets. *Id.*

239. 29 U.S.C. § 1106(a).

240. See discussion *supra* Part III.A.2.

The party in interest prohibited transaction rules broadly prohibit a fiduciary of the plan from causing the plan to enter into various types of transactions between the plan and a party in interest that involve plan assets.<sup>241</sup> The premise underlying the party in interest prohibited transaction rules is that a party in interest, by definition, has some connection with the plan or the plan's sponsor that may potentially influence the judgment of the plan's fiduciary in authorizing the transaction between the plan and the party in interest.<sup>242</sup>

Fiduciary prohibited transactions under Section 406(b) are based on the premise that a fiduciary of a plan must have an undivided duty of loyalty to the plan.<sup>243</sup> Section 406(b) prohibits a fiduciary from engaging in a self-dealing transaction involving plan assets.<sup>244</sup> A fiduciary also cannot engage in a transaction where a conflict of interest exists, directly or indirectly, between the fiduciary and the plan or the participants of the plan.<sup>245</sup> Finally, a fiduciary is prohibited from receiving a "kickback" from a third party who transacts with the plan.<sup>246</sup>

The fiduciary prohibited transaction rules of Section 406(b) obviously overlap with the fiduciary's duty of loyalty under Section 404(a)(1)(A). In assigning statutory provisions to groups of claims, I assigned the fiduciary prohibited transaction rules to Group 4 claims having the common characteristic of being a prohibited transaction, rather than assigning such claims to Group 3. I preserved fiduciary prohibited transactions as part of a separate claim group (rather than merging such claims into Group 3 claims) at this stage of the modeling exercise because the *per se* nature of a prohibited transaction violation eliminates the sometimes difficult burden of proving causation of injury to the plan that

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241. Section 406(a) prohibits the direct or indirect sale or exchange of property, the lending of money or other extension of credit, and the furnishing of goods, services, or facilities between the plan and a party in interest. Section 406(a) also prohibits the direct or indirect transfer of plan assets to, or use by, or for the benefit of, a party in interest. 29 U.S.C. § 1106(a)(4). Section 406(a)(5) prohibits the acquisition by the plan of any employer security or employer real property in excess of certain limits specified in section 407 of title I of ERISA. 29 U.S.C. § 1106(a)(1)-(5).

242. See *Comm'r v. Keystone Consolidate Ind., Inc.*, 508 U.S. 152, 160 (1993) ("Congress' goal was to categorically bar a transaction that was likely to injure the pension plan."); *Donovan*, 716 F.2d at 1464-65.

243. 29 C.F.R. § 2550.408b-2(e)-1; Morton Kleven, *The Fiduciary's Duty of Loyalty Under ERISA Section 406(b)(1)*, 23 REAL PROP. PROB. & TR. J. 561, 561-64 (1988).

244. 29 U.S.C. § 1106(b)(1) (2000).

245. 29 U.S.C. § 1106(b)(2).

246. 29 U.S.C. § 1106(b)(3).

must be established for a breach of fiduciary duty claim.<sup>247</sup> On the same set of facts, this additional burden of proof could cause a breach of fiduciary duty claim to fail, whereas a fiduciary prohibited transaction claim could succeed.

#### 5. *Violation of Plan Terms*

Group 5 claims are distinct from the first four groups of claims because the underlying common characteristic is an alleged violation of the terms of an employee benefit plan. Group 5 claims expressly are authorized by Section 502(a)(3) to enforce the written terms of the plan document. Because ERISA preempts state law breach of contract claims,<sup>248</sup> a claim to enforce the terms of the plan under Section 502(a)(3) is the only statutory mechanism available to remedy a violation of the written terms of the plan.

Given that Group 5 claims originate from the terms of the plan document rather than the statutory provisions of title I, in theory, it is possible to have an unlimited number of Group 5 claims. As a practical matter, Group 5 claims usually center around the past, present, or future payment of money from the plan.<sup>249</sup>

#### 6. *The Question of "Omitted" (Federal Common Law) Claims*

The second order analysis of the modeling exercise assumed that a viable claim under Section 502(a)(3) must be a claim that asserts an express statutory violation or a claim to enforce the express terms of the plan. This assumption necessarily foreclosed the possibility that additional claims could be *implied* under Section 502(a)(3) as part of the federal common law of ERISA. I use the term "federal common law claim" in this part of the Article and in Appendix A to describe any claim brought under Section 502(a)(3) that does not allege a violation of an express statutory provision of title I of ERISA or the terms of a plan.

The status of federal common law claims under ERISA is controversial. Some federal judges apparently view the creation of federal common law claims under ERISA as a regular occurrence and one well within the federal judiciary's prerogative.<sup>250</sup> Other

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247. See COLLEEN E. MEDILL, INTRODUCTION TO EMPLOYEE BENEFITS LAW: POLICY AND PRACTICE, 530 (2004).

248. 29 U.S.C. § 1144(a) (2000).

249. See discussion *infra* Parts III.C.3.d. & f.

250. See *Beach v. Commonwealth Edison Co.*, 382 F.3d 656, 659 (7th Cir. 2004) (stating that "ERISA preempts state law relating to pension plans, and federal courts regularly create federal common law (based on contract and trust law) to fill the gap.").

federal judges appear to be reluctant to recognize federal common law claims due to the concern that implying such claims usurps Congress's legislative authority.<sup>251</sup> Still other federal judges view implied federal common law claims under ERISA as permissible, but only in exceptional circumstances.<sup>252</sup>

Section 502(a)(3) presents the possibility for federal common law claims because the statutory language awkwardly juxtaposes the distinct legal concepts of a *claim* and a *remedy*. Section 502(a)(3) begins by describing the universe of possible *claims* as any private civil action brought by a participant or fiduciary to enforce the statutory provisions of title I of ERISA or the terms of an employee benefit plan. The statutory language then concludes by defining the available *remedies* as consisting of either injunctive or "other appropriate equitable relief."<sup>253</sup>

Ideally, Congress would have drafted Section 502(a)(3) much more precisely by sorting through the statutory scheme, identifying the various possible statutory claims, and specifying the remedy for each statutory claim. Instead, what Congress did in drafting Section 502(a)(3) was effectively to delegate this task to the federal judiciary.

Although the clumsy statutory language of Section 502(a)(3) leaves open the possibility, there are several reasons why the better interpretation is to read Section 502(a)(3) as excluding federal common law claims. Excluding federal common law claims is more consistent with the overall statutory scheme of title I of ERISA and with the doctrine of complete preemption. Moreover, close examination of the most prevalent federal common law claims that have been asserted under Section 502(a)(3) reveals that such claims are either unnecessary because a statutory-based claim is available, or such claims are an illegitimate attempt to circumvent the statutory scheme of fiduciary liability established by title I of ERISA. For these reasons, I excluded federal common law claims from modeling exercise. A detailed discussion of my reasoning in excluding federal common law claims is contained in Appendix A of the Article.

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251. See *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54, 58 (4th Cir. 1992) ("Federal common law, however, does not grant federal 'courts carte blanche authority. . . to re-write a federal statute.'").

252. See *Local 6-0682 Int'l. Union of Paper Workers v. Nat'l. Indus. Group Pension Plan*, 342 F.3d 606, 609 (6th Cir. 2003) ("Federal courts do have a certain latitude to create federal common law under ERISA. This authority, however, is limited to instances in which ERISA is 'silent or ambiguous,' where there is an 'awkward gap in the statutory scheme,' or where it may 'be said that federal common law is essential to the promotion of fundamental ERISA policies.'").

253. 29 U.S.C. § 1132(a)(3) (2000).

### 7. *Intertwined Fiduciary Claims*

In reviewing all of the statutory provisions of title I of ERISA and assigning each provision to a group of claims based on common characteristics, I found numerous statutory provisions that directly or indirectly require a fiduciary of the plan to act or refrain from acting. If the fiduciary failed to comply with these statutory requirements, then in addition to a statutory violation the fiduciary's conduct also would constitute a breach of the fiduciary's duty of prudence under Section 404(a)(1)(B).<sup>254</sup> I call this phenomenon the *problem of intertwined fiduciary claims*.

The phenomenon of intertwined fiduciary claims under Section 502(a)(3) arises because the same set of circumstances can generate a breach of fiduciary duty claim as well as a claim based on another statutory provision. The problem of intertwined fiduciary claims is not limited to the fiduciary's duty of prudence. Intertwined fiduciary claims also exist for the fiduciary's duty of loyalty,<sup>255</sup> the fiduciary's duty of prudent diversification,<sup>256</sup> and the fiduciary's duty to follow (or disregard) the written terms of the plan.<sup>257</sup>

The phenomenon of intertwined fiduciary claims likely contributes to the judicial perception that Section 502(a)(3) presents a judicial slippery slope. To better understand the phenomenon of intertwined fiduciary claims, as part of the modeling exercise I focused on the following two questions:

- (1) Why does a breach of fiduciary duty claim become intertwined with the other four groups of claims that are possible under Section 502(a)(3)?
- (2) What makes a breach of fiduciary duty claim distinct from each of the other four groups of claims that are possible under Section 502(a)(3)?

Close examination of the answers to these two questions revealed that the phenomenon of intertwined fiduciary claims does not present an obstacle to identifying discrete categories of defendants and related claims under Section 502(a)(3). A detailed description of the analysis I used in arriving at this conclusion is contained in Appendix B.

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254. 29 U.S.C. § 1104(a)(1)(B) (2000).

255. 29 U.S.C. § 1104(a)(1)(A) (2000).

256. 29 U.S.C. § 1104(a)(1)(C) (2000).

257. 29 U.S.C. § 1104(a)(1)(D) (2000).



### 8. *Conclusion: The Plaintiff-Defendant-Claim Matrix*

Consolidating the statutory requirements of title I of ERISA into four groups of statutory claims and adding a fifth group of claims based on a violation of the terms of the plan resulted in a three column, 2 by 6 by 5 model matrix. This matrix is presented in Table 3.

TABLE 3  
THE PLAINTIFF-DEFENDANT-CLAIM MATRIX

<u>PLAINTIFF</u>	<u>DEFENDANT</u>	<u>CLAIM</u>
1. Participants	1. Employee Benefit Plan	1. Plan Design Requirements
2. Fiduciaries	2. Employers	2. Retaliation, Improper Amendment Procedures, or
	3. Fiduciaries	Inurement of Plan Assets
	4. Participants	3. Breach of Fiduciary Duties
	5. Parties In Interest	4. Prohibited Transactions
	6. Third Parties	5. Plan Terms

### C. *Third Order Analysis: Deducing the Universe of Section 502(a)(3) Claims*

#### 1. *Consolidation Principles Used in the Third Order Analysis*

The result of the second order analysis was a plaintiff-defendant-claim matrix that produced sixty possible combinations of plaintiffs, defendants, and claims. The third order analysis consolidated these sixty possible combinations into six distinct categories of defendants and related claims. Appendix C documents in detail the procedure I used to arrive at the six categories of defendants and related claims. The discussion below summarizes this process.

Impossibility eliminated thirty-six combinations for one of two reasons. Some combinations were impossible because the

defendant could not cause the violation that gave rise to the underlying claim.<sup>258</sup> Other combinations were impossible because the settlor function doctrine protects the employer, as a defendant, from fiduciary liability.<sup>259</sup>

In several instances, the only distinction between certain combinations was that the combination involved a different type of plaintiff. Where the defendant and the claim were the same, I consolidated by grouping these defendants and related claims together.<sup>260</sup> This resulted in each of the six categories having as possible plaintiffs either participants (defined to include beneficiaries) or fiduciaries.

I further consolidated where a common statutory source produced multiple claims. This consolidation affected two sets of defendants and related claims. In the first set, the statutory source for claims under Section 502(a)(3) against a nonfiduciary who participated in either a breach of fiduciary duty or a prohibited transaction is Section 502(l) of ERISA.<sup>261</sup> Because these claims originated from a common statutory source, I consolidated the affected combinations into a single category.<sup>262</sup>

In the second set, my reasoning was that both fiduciary duties and the prohibited transaction rules derive from a common statutory source, the “Fiduciary Responsibility” provisions found in part 4 of title I of ERISA.<sup>263</sup> This common statutory source justified consolidation of claims against a fiduciary for authorizing or engaging in a prohibited transaction with breach of fiduciary duty claims into a single category having fiduciaries as defendants.<sup>264</sup>

After consolidating the combinations, six distinct categories of defendants and related claims emerged as the final result of the modeling exercise. The six categories of defendants and related claims that form the universe of private civil actions possible under Section 502(a)(3) are presented in Table 4.

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258. These combinations are labeled as “Impossible” in Appendix C.

259. See discussion *infra* Part III.D.1 (discussing the settlor function). These combinations are labeled as “not possible due to settlor function doctrine” in Appendix C.

260. These combinations are labeled as “common defendant/common claim” in Appendix C.

261. See discussion *infra* Part III.C.3.e.

262. See *infra* Appendix C, combinations #33-36, #45-48.

263. 29 U.S.C. §§ 1101-1114 (2000); see *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 143 (1985).

264. See *infra* Appendix C, combinations #29-30, #41-42

TABLE 4  
THE SIX CATEGORIES OF DEFENDANTS AND RELATED CLAIMS

<u>CATEGORY</u>	<u>PLAINTIFF(S)</u>	<u>DEFENDANT</u>	<u>CLAIM</u>
Category I	Participants/ Fiduciaries	Employee Benefit Plan	Plan Design Requirements
Category II	Participants/	Employers	Retaliation, Improper Amendment Procedures, or Inurement of Plan Assets
Category III	Participants/ Fiduciary	Fiduciaries	Breach of Fiduciary Duties (Including Wrongfully Denied Claims for Plan Benefits)
Category IV	Participants/ Fiduciaries	Participants	Violation of Plan Terms
Category V	Participants/ Fiduciaries	Parties In Interest (Nonfiduciary)	Knowing Participation In Breach of Fiduciary Duties Or Engaging In Prohibited Transactions
Category VI	Participants/ Fiduciaries	Third Parties	Knowing Participation In Breach of Fiduciary Duties, Engaging In Prohibited Transactions, or Violation of Plan Terms

*2. Claims Expressly Authorized by Other Provisions of Section 502(a)*

At this stage in the modeling exercise I considered the context of Section 502(a)(3) within the overall structure of ERISA's civil

claims and remedies provision, Section 502(a).<sup>265</sup> Section 502(a)(3) is preceded by two other significant subsections – 502(a)(1)(B)<sup>266</sup> and 502(a)(2)<sup>267</sup> – that authorize specific types of claims and remedies. Based on the reasoning of the Supreme Court's decisions in *Varity*<sup>268</sup> and *Russell*,<sup>269</sup> I examined whether each of the six categories in Table 4 above contained a claim specifically addressed by these other subsections of Section 502(a). If so, I further asked whether the remedy under the other subsection should be exclusive, or whether additional equitable relief might be appropriate in individual cases under Section 502(a)(3). I concluded that claims under Section 502(a)(1)(B) could give rise to a claim for additional equitable relief under Section 502(a)(3) based on a breach of fiduciary duty claim. I further concluded that some Category III claims for breach of fiduciary duty should be limited exclusively to the remedies of Section 502(a)(2).

a. Section 502(a)(1)(B) Claims

Section 502(a)(1)(B) authorizes a participant to bring a civil action to appeal a claim for plan benefits denied by the plan's administrator.<sup>270</sup> Section 502(a)(3) provides a mechanism to provide additional individualized relief beyond the limited remedy available under Section 502(a)(1)(B) for injury caused by a plan administrator's wrongful denial of a claim for plan benefits. To date, the lower federal courts have refused to grant such additional relief under Section 502(a)(3) based on the Supreme Court's statements concerning the relationship between Section 502(a)(1)(B) and Section 502(a)(3) in *Varity Corp. v. Howe*.<sup>271</sup>

In *Varity*, the plan participants brought a claim under Section 502(a)(3) for individual relief for breach of fiduciary duty based on false statements, knowingly and intentionally made by the employer in its fiduciary capacity, concerning the future financial viability of the employer's health care plan. One of the objections to the plaintiffs' claim for individual relief under Section 502(a)(3), made by amici counsel in support of the defendant employer, was that permitting breach of fiduciary duty claims by individual participants would "complicate ordinary benefit claims by dressing them up in 'fiduciary duty' clothing."<sup>272</sup> In rejecting this argument, the Supreme Court stated in relevant part:

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265. 29 U.S.C. § 1132(a)(2000).

266. 29 U.S.C. § 1132(a)(1)(B).

267. 29 U.S.C. § 1132(a)(2).

268. *Varity Corp. v. Howe*, 516 U.S. 489 (1996).

269. *Russell*, 473 U.S. 134.

270. *See* 29 U.S.C. § 1132(a)(1)(B).

271. 516 U.S. 489 (1996).

272. *Id.* at 514.

Second, characterizing a denial of benefits as a breach of fiduciary duty does not necessarily change the standard a court would apply when reviewing the administrator's decision to deny benefits. After all, *Firestone*, which authorized deferential court review when the plan itself gives the administrator discretionary authority, based its decision upon the same common-law trust doctrines that govern standards of fiduciary conduct. . . . Third, the statute authorizes "appropriate" equitable relief. We should expect that courts, in fashioning "appropriate" equitable relief, will keep in mind the special nature and purpose of employee benefit plans, and will respect the policy choices reflected in the inclusion of certain remedies and the exclusion of others. Thus, we should expect that where Congress elsewhere provided adequate relief for a beneficiary's injury, there will likely be no need for further equitable relief, in which case such relief normally would not be "appropriate."<sup>273</sup>

Although this statement from *Varity* is clearly dicta, it has proven to be powerful dicta nonetheless. Post-*Varity*, the lower federal courts have uniformly rejected claims for additional equitable relief under Section 502(a)(3) for individual injuries to participants caused by a plan administrator's wrongful denial of plan benefits.<sup>274</sup>

Closer examination of these statements in *Varity* suggests that the Supreme Court did not prohibit absolutely the availability of additional equitable relief under Section 502(a)(3). Rather, these statements can be read to suggest a much more sophisticated analytical approach to the interrelationship between Section 502(a)(1)(B) and Section 502(a)(3). First and foremost, the *Varity* Court's remarks implicitly affirm that the conduct of the administrator in interpreting the plan is *fiduciary in nature* because this power derives from the principles developed under the common law of trusts and the duties of the trustee in administering the terms of the trust. Second, the *Varity* Court's statements can be read as suggesting that considerations of additional equitable relief under Section 502(a)(3) should be policy-driven. The policy objectives implicated by the nature of the particular claim can be used to discern whether relief under Section 502(a)(3), in addition to the relief provided by Section 502(a)(1)(B), would be "appropriate" under the totality of the circumstances. It is only with these caveats that the *Varity* Court concludes that additional relief under Section 502(a)(3) "normally would not be 'appropriate.'"<sup>275</sup>

What was left unsaid by the Supreme Court in *Varity* was a discussion of the alternative situation, namely that under some

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273. *Id.* at 514-15 (quotations and citations omitted).

274. *See Larocca v. Borden*, 276 F.3d 22, 28-29 (1st Cir. 2002) (collecting federal circuit court cases).

275. 516 U.S. at 515 (emphasis added).

circumstances the policy objectives that underlie ERISA may make additional relief under Section 502(a)(3) “appropriate” when a participant has been injured by a plan administrator’s wrongful denial of a claim for plan benefits. The Supreme Court’s first point – that the conduct of the administrator in interpreting the terms of the plan is fiduciary in nature – forms the starting point for connecting the proverbial dots of the Supreme Court’s cryptic statements in *Varity* and constructing a theory of the interrelationship between Section 502(a)(1)(B) and Section 502(a)(3).

If fully articulated, a plausible theory based on *Varity* would employ the following logic. When an administrator abuses its fiduciary discretion in interpreting the terms of the plan to deny the participant’s claim for benefits, the administrator has, at a minimum, also breached his fiduciary duty to *follow the terms of the plan* under Section 404(a)(1)(D).<sup>276</sup> To automatically award additional equitable relief under Section 502(a)(3) as a *per se* breach of fiduciary duty would, as the *Varity* Court noted, render the distinction between claims filed under Section 502(a)(1)(B) and claims filed under Section 502(a)(3) meaningless. Thus, the “normal” outcome of a successful claim for wrongfully denied plan benefits under Section 502(a)(1)(B) will be the limited remedy provided under that provision.

There may, however, be circumstances where the policies underlying ERISA justify awarding additional relief under Section 502(a)(3) to supplement the limited remedy afforded by Section 502(a)(1)(B). Additional relief under Section 502(a)(3) *is permissible* based on the plan administrator’s underlying breach of fiduciary duty in wrongfully interpreting the terms of the plan.

Based on this logic, I retained a claim for breach of fiduciary duty in wrongfully interpreting the terms of the plan as a special subset of Category III claims for breach of fiduciary duty. Later in Part III.D.3 of the Article, I propose a standard for the federal courts to use in determining when additional relief under Section 502(a)(3), based on a wrongfully denied claim for plan benefits, would be “appropriate.”

#### b. Section 502(a)(2) Claims and the Payee Principle

Section 502(a)(2)<sup>277</sup> authorizes a participant or fiduciary to bring a civil action for relief under Section 409.<sup>278</sup> Section 409(a),

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276. 29 U.S.C. § 1104(a)(1)(D) (2000). The administrator’s decision also could have been motivated by considerations other than the interests of the plan participants, such as a conflict of interest, that would give rise to a claim of breach of the fiduciary duty of loyalty under Section 404(a)(1)(A), 29 U.S.C. § 1104(a)(1)(A) (2000).

277. 29 U.S.C. § 1132(a)(2) (2000).

278. 29 U.S.C. § 1109 (2000).

in turn, imposes personal liability on a fiduciary for a breach of fiduciary duty that causes a loss to the plan itself, and further requires that a fiduciary who profits from the use of plan assets must restore such profits to the plan.<sup>279</sup> In addition, Section 409(a) authorizes other “equitable or remedial relief as the court may deem appropriate.”<sup>280</sup> As interpreted by the Supreme Court in *Massachusetts Mutual Life Insurance Co. v. Russell*,<sup>281</sup> the remedies available under Section 409 are limited to the plan “as a whole.”<sup>282</sup> Thus, *Russell* functions to divide breach of fiduciary duty claims between claims for relief to the plan “as a whole,” and claims for “individual” relief under Section 502(a)(3).

A clear standard defining a claim for relief to the plan “as a whole” has eluded the federal courts when the claim involves a retirement plan with individual participant accounts.<sup>283</sup> In an earlier article entitled *Stock Market Volatility and 401(k) Plans*, I identified this characterization issue and suggested that the “payee principle” should be used to resolve it.

[T]he better judicial interpretation. . . is to view the relief as flowing to the plan in accord with section 502(a)(2), so long as the monetary award is. . . allocated to each participant’s plan account rather than to his personal pocketbook. . . [A]n award of money damages to the plan [under Sections 502(a)(2) and 409(a)] will be made payable directly to the plan’s trustee. The plan trustee will then allocate the payment among the participant’s individual accounts. . . [T]his approach is consistent with ERISA’s fundamental purpose of protecting and preserving the retirement benefits the [individual account] plan provides to its participants.<sup>284</sup>

Since the publication of *Stock Market Volatility and 401(k) Plans* in 2001, the policy justification for the payee principle has been officially recognized by the Internal Revenue Service. In Revenue Ruling 2002-45, the Service concluded that an employer may make a “restorative payment” to a qualified retirement plan to remedy a claimed or adjudicated breach of fiduciary duty without a violation of the restrictions imposed on employer contributions to qualified retirement plans under Internal Revenue Code Sections 404 and 415.<sup>285</sup> The policy justification for waiving application of these Internal Revenue Code requirements, which normally would restrict the amount of the employer’s contributions to a qualified retirement plan, is to allow the

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279. § 1109(a).

280. § 1109(a).

281. 473 U.S. 134 (1985).

282. *Id.* at 140.

283. See discussion *supra* Part II.A.3.

284. Colleen E. Medill, *Stock Market Volatility and 401(k) Plans*, 34 MICH. J.L. REFORM 469, 529 (2001).

285. Rev. Rul. 2002-45, 2002-2 C.B. 116.

participants to receive the substantial economic benefits associated with the deferral of income taxation of investment earnings from assets held inside the plan.

Although adoption of the payee principle by the federal judiciary will reduce the volume of breach of fiduciary duty claims brought under Section 502(a)(3), there are still numerous instances where a breach of fiduciary duty claim would require relief in the form of a monetary payment to an individual plaintiff-participant rather than to the trustee of the plan.<sup>286</sup> The concept of a breach of fiduciary duty claim under Section 502(a)(3), brought in connection with a wrongfully denied claim for plan benefits under Section 502(a)(1)(B), provides one such example. I describe other varieties of these “true” Section 502(a)(3) claims for individual monetary relief for a breach of fiduciary duty later in Part III.C.3 of the Article.

### 3. *“Testing” the Model Results: Discussion and Illustrations of the Six Categories of Section 502(a)(3) Claims*

One way to test the validity of the results produced by the modeling exercise is to compare the six categories with actual claims brought before the federal courts under Section 502(a)(3). In this part of the Article, I perform a comparative analysis and illustrate the six categories with actual cases. The model appears to be highly predictive of claims previously litigated in federal courts under Section 502(a)(3).

A secondary purpose of the modeling exercise was to seek to identify claims that are possible as a matter of theory under Section 502(a)(3), but that have not yet appeared in the federal courts. Based on the model results, there appear to be several such claims in Category V (claims against a nonfiduciary party in interest) and in Category VI (claims against third parties). This part of the Article discusses these claims and the underlying theory that justifies their future recognition by the federal courts.

#### a. Category I: Violation of Plan Design Requirements

Category I claims are brought directly against the plan<sup>287</sup> for a violation of ERISA’s statutory requirements for plan design. Given that title I of ERISA imposes many more statutory plan design requirements for pension plans than for welfare benefit plans, it is not surprising that most reported decisions involving Category I claims involve pension plans.

In the pension plan context, Category I claims are illustrated by cases brought by plan participants that challenge the design of

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286. See discussion *supra* Part II.A.3.

287. The plan itself may be sued as an entity. See 29 U.S.C. § 1132(d)(1) (2000).



cash balance pension plans<sup>288</sup> or the manner in which benefits accrued under a traditional defined benefit pension plan are calculated once the plan has been converted to a cash balance plan.<sup>289</sup> Other Category I claims allege that the pension plan's benefit design violates ERISA's vesting rules<sup>290</sup> or benefit accrual rules,<sup>291</sup> or results in a prohibited cutback of the participants' statutorily protected accrued benefits.<sup>292</sup>

As originally enacted, title I of ERISA did not contain statutory plan design requirements for welfare benefit plans, other than the requirements that the plan must have a governing plan document naming a plan fiduciary, and that any plan assets must be held in a trust.<sup>293</sup> Later, Congress enacted statutory requirements for the benefit design of health care plans as part of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"),<sup>294</sup> the Newborns' and Mothers' Health Protection Act of 1996 ("NMHPA"),<sup>295</sup> the Mental Health Parity Act of 1996 ("MHPA"),<sup>296</sup> and the Women's Health and Cancer Rights Act of 1998 ("WCHRA").<sup>297</sup> These laws, which resulted in amendments to title I of ERISA, do not authorize a separate claim under Section 502(a)(3) for their enforcement.<sup>298</sup> A claim alleging a violation of

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288. See, e.g., *Eaton v. Onan Corp.*, 117 F. Supp. 2d 812 (S.D. Ind. 2000).

289. For example, several federal appellate courts have ruled that the interest rate used in calculating the participant's lump sum benefit in a cash balance plan violated ERISA's cash out rule, 29 U.S.C. § 1053(c) (2000). See *Esden v. Bank of Boston*, 229 F.3d 154, (2d Cir. 2000); *Lyons v. Georgia-Pacific Corp.*, 221 F.3d 1235 (11th Cir. 2000).

290. See, e.g., *Smith v. Contini*, 205 F.3d 597, 603-04 (3rd Cir. 2000) (violation of minimum vesting requirements).

291. See, e.g., *DeVito v. Pension Plan of Local 819 I.B.T. Pension Fund*, 975 F. Supp. 258, 267-70 (S.D.N.Y. 1997) (violation of minimum benefit accrual requirements).

292. See *Central Laborers' Pension Fund v. Heinz*, 541 U.S. 739, 743-45 (2004) (holding that anti-cutback rule applied to a suspension of benefits clause in a multi employer plan); *Hoover v. Cumberland, Md. Area Teamsters Pension Fund*, 756 F.2d 977, 981-84 (3rd Cir. 1985) (violation of rule prohibiting reductions of accrued benefits); *Laurenzano v. Blue Cross and Blue Shield of Mass., Inc. Ret. Income Trust*, 134 F. Supp. 2d 189, 197-201 (D. Mass. 2001) (violation of rule prohibiting reductions of accrued benefits).

293. See 29 U.S.C. §§ 1102-1103 (2000) (plan document and trust requirements); § 1051(l) (2000) (excluding welfare benefit plans from part 2 of title I of ERISA); § 1081(l) (2000) (excluding welfare benefit plans from part 3 of title I of ERISA).

294. Pub. L. No. 104-191, § 101, 110 Stat. 1936 (1996) (codified at 29 U.S.C. §§ 1181-82).

295. Pub. L. No. 104-204 § 601, 110 Stat. 2935 (1996) (codified at 29 U.S.C. § 1185).

296. Pub. L. No. 104-204 § 701, 110 Stat. 2944 (codified at 29 U.S.C. § 1185a).

297. Pub. L. No. 105-277, Pub. L. No. 104-204 § 701, 110 Stat. 2944 (codified at 29 U.S.C. § 1185a). 901, 112 Stat. 2681 (codified at 29 U.S.C. § 1185b).

298. See *supra* notes 294-297; *Howard v. Coventry Health Care*, 293 F.3d

these statutory requirements must be brought under Section 502(a)(3) as a Category I claim.

Although there have been few reported decisions to date,<sup>299</sup> it is inevitable that such Category I claims against health care plans will be brought with increasing frequency in the future. A random study conducted by the Department of Labor in 2001 documented a system-wide problem of lack of compliance by health care plans with ERISA's statutory requirements.<sup>300</sup> The study found that a significant percentage of health care plans were in violation of the statutory requirements of HIPAA, NMHPA, MHPA, and WCHRA.<sup>301</sup> Eventually, plan participants (and their attorneys) will become more knowledgeable of their rights concerning health care plan benefits under these federal statutory standards. The result is likely to be more Category I claims under Section 502(a)(3) brought in the federal courts.

b. Category II: Retaliation, Inurement of Plan Assets, or Improper Amendment Procedures

Category II claims share the common characteristic that the statutory provisions at issue regulate the conduct of the employer when the employer is not acting in a fiduciary capacity with respect to the plan.<sup>302</sup> These claims are rooted in the historical problems associated with employee benefit plans that preceded the enactment of ERISA.<sup>303</sup>

i. Retaliation Claims Under Section 510

The classic illustration of employer retaliation under Section 510 is the infamous case of *Gavalik v. Continental Can Co.*<sup>304</sup> In *Continental Can*, the employer "red flagged" employees who were about to satisfy the plan's eligibility requirements for pension benefits and systematically laid them off before they could satisfy the plan's service requirement for the pension benefits.

Although Section 510 claims traditionally have been

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442, 444-45 (8th Cir. 2002) (refusing to imply a private civil course of action under WCHRA).

299. See *Krauss v. Oxford Health Plans, Inc.*, No. 04 Civ. 6080, 2005 WL 3465627, at \*8 (S.D.N.Y. Dec. 13, 2005) (alleging WCHRA violation based on plan terms defining covered benefits).

300. U.S. DEP'T OF LABOR, HEALTH DISCLOSURE AND CLAIMS ISSUES: FISCAL YEAR 2001 COMPLIANCE PROJECT REPORT (Jan. 2003).

301. *Id.* at 10-16. Of the substantive violations, fully 23.8% of the noncompliance found by the Department of Labor involved HIPAA's restrictions on when a plan may impose a coverage exclusion for a pre-existing health condition. *Id.* at 13.

302. See discussion *supra* Part III.B.2.

303. See generally AMERICAN BAR ASS'N, EMPLOYEE BENEFITS LAW, 1-6 (2d ed. 2000).

304. 12 F.2d 834 (3d Cir. 1987).

associated with pension plans due to their vesting requirements for plan benefits, the Supreme Court has made clear that a Section 510 claim may also be brought in the context of a welfare benefit plan.<sup>305</sup> For example, Section 510 clearly prohibits the employer from *firing* an employee because the employee, a spouse, or a dependent has incurred expensive claims under the employer's health care plan.<sup>306</sup> The federal courts are divided over whether Section 510 prohibits an employer from *refusing to hire* an employee due to potentially expensive claims if the employer's health care plan covers the employee, a spouse, or a dependent of the employee.<sup>307</sup>

ii. *Inurement Claims Under Section 403(c)(1)*

Section 403(c)(1) of ERISA<sup>308</sup> prohibits the most blatant abuse of plan assets by preventing the employer from reclaiming and using for the employer's own benefit the assets of the plan once those assets have been transferred to the plan's trust. Although Section 403(c)(1) partially duplicates the statutory language of the fiduciary duty of loyalty found in Section 404(a)(1)(A),<sup>309</sup> such duplication is necessary because, unlike Section 404(a)(1)(A), the inurement rule applies to the employer even when the employer is *not* acting as a fiduciary with respect to the plan. In most instances, of course, where an employer is dealing with plan assets the employer also will be acting as a fiduciary,<sup>310</sup> and therefore Section 404(a)(1)(A) will apply. As a result, Section 403(c)(1) inurement claims brought against the employer in a nonfiduciary capacity are infrequent.

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305. See *Inter-Modal Rail Employees Ass'n v. Atchison, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510, 514-15 (1997) (noting that Congress' use of the word "plan" indicates an intent to apply Section 510 to non-vested employee welfare benefit plans).

306. See *Folz v. Marriott Corp.*, 594 F. Supp. 1007, 1014 (W.D. Mo. 1984).

307. Compare *Fleming v. Ayers & Assoc.*, 948 F.2d 993, 997-98 (6th Cir. 1991) (stating that employer's refusal to hire employee due to medical plan costs for coverage of employee's disabled infant violated Section 510) with *Becker v. Mack Trucks, Inc.* 281 F.3d 372, 383 (3d Cir. 2002) (stating that Section 510 applies only in the context of an ongoing employer-employee relationship).

308. 29 U.S.C. § 1103(c)(1) (2000). Section 403(c)(1) provides in relevant part that "the assets of a plan...shall never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan."

309. See 29 U.S.C. § 1104(a)(1)(A) (2000).

310. See 29 U.S.C. § 1002(21)(A)(i) (2000) (stating that a person is a fiduciary when exercising any authority or control over the management or disposition of plan assets).

*Hughes Aircraft Co. v. Jacobson*<sup>311</sup> illustrates the unique circumstances when an individual may bring an inurement claim under Section 403(a)(1) against the employer in a nonfiduciary capacity. In *Jacobson*, the employer amended the benefit provisions of its defined benefit pension plan so that part of the plan's accumulated surplus was used to pay enhanced early retirement benefits under the employer's early retirement incentive program. Later, the employer amended the plan so that part of the surplus would pay for pension benefits to new participants who, unlike the plan's existing participants, were not required to contribute to the plan. During this time the employer itself suspended contributions to the plan because the plan's surplus, accumulated in part from prior mandatory employee contributions to the plan, made further employer contributions unnecessary under ERISA's minimum funding standards.

A group of plan participants brought a claim against the employer alleging that these plan amendments resulted in the improper inurement of the plan's surplus assets to the benefit of the employer in violation of Section 403(c)(1). Because an employer who amends its plan is acting as a settlor, not as a fiduciary,<sup>312</sup> the participants could not sue the employer for a breach of fiduciary duty in amending the terms of the plan under Section 404(a)(1)(A). One of the claims made by the plaintiffs in *Jacobson* was that the plan assets improperly had inured to the benefit of the employer in violation of Section 403(c)(1) because the plan's surplus assets effectively were used to finance the employer's early retirement incentive program. In rejecting the plaintiffs' inurement claim under Section 403(c)(1), the Supreme Court emphasized that no inurement violation had occurred because the employer ultimately used the plan's assets to pay pension plan benefits to other participants in the plan.<sup>313</sup>

The *Jacobson* reasoning suggests that, conversely, an inurement claim against the employer would arise if the employer paid the plan's assets out of the plan for a purpose other than the payment of benefits to participants. To illustrate, assume that the employer has established two separate plans, a pension plan and a self-insured health care plan for its employees. The pension plan has a funding surplus, but the health care plan does not have sufficient assets to pay participant health care plan claims. If the employer amends the terms of the pension plan so that its surplus assets are used to pay the claims of participants under the health care plan, the employer's conduct under the reasoning in *Jacobson* would violate the inurement rule. In this example, although the

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311. 525 U.S. 432 (1999).

312. See discussion *infra* Part III.D.1.

313. *Jacobson*, 525 U.S. at 441-43.

pension plan's surplus assets are used to pay benefits to plan participants, the benefits being paid would not be the benefits promised to participants under the terms of the pension plan. Under these circumstances, the employer's amendment would result in the inurement of the pension plan's assets for the benefit the employer, who otherwise would be required to contribute funds to pay participant claims under the self-insured health care plan.

A similar inurement claim would arise if the employer's amendment merely authorized a loan from the pension plan to the self-insured health care plan.<sup>314</sup> If the amendment authorizing the loan was on terms that were at a market rate of investment return, the loan might be difficult to challenge as a breach of fiduciary duty.<sup>315</sup> The loan could be challenged as a prohibited transaction,<sup>316</sup> but that claim must be brought against the fiduciary that authorized the transaction (i.e., the plan's administrator), who may not be the same person as the employer. In this situation, a Category II claim for inurement might be the only possible claim against the employer available under title I of ERISA.

### *iii. Improper Plan Amendment Procedure*

A Category II claim may challenge a plan amendment as improper because the employer did not follow the amendment procedure that is required to be part of every plan document pursuant to Section 402(b)(3).<sup>317</sup> This statutory requirement is part of the written plan document rule codified in Section 402. Under the written plan document rule, "every covered employee benefit plan. . . is to be established and maintained in writing."<sup>318</sup> The purpose of the written plan document rule is to provide assurance to participants that they may examine the plan

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314. *Cf. Donovan v. Mazzola*, 716 F.2d 1226, 1238-39 (9th Cir. 1983) (finding trustee's authorization of below market rate loan from over-funded pension plan fund to under-funded welfare benefit plan fund violated Section 404(a)(1)(A)).

315. This is because a breach of fiduciary duty claim would further require proof of causation and loss to the plan. *MEDILL*, *supra* note 247, at 530. If the loan is at market rate, the surplus pension plan may not suffer an investment loss.

316. *See* 29 U.S.C. § 1106(a)(1)(B) (2000) (prohibiting the loaning of money or other extension of credit between a plan and a party in interest). To sustain this prohibited transaction claim, the health care plan would have to qualify as a party in interest with respect to the pension plan under Section 3(14) of ERISA, 29 U.S.C. § 1002(14) (2000). My reading of Section 3(14) is that there is no provision that would apply to make the health care plan a party in interest based on these hypothetical facts.

317. 29 U.S.C. § 1102(b)(3) (2000).

318. *See* H.R. REP. NO. 93-1280, pt. V (1973), *reprinted in* 1974 U.S.C.C.A.N. at 5038, 5077.

document and know with certainty their rights under the plan and who is responsible for operating the plan.<sup>319</sup>

Implicit in Section 402(b)(3) is the principle that the employer must follow the plan's stated procedure to amend the terms of the written plan document. From a policy perspective, Section 402(b)(3) serves a dual notice-reliance function. Participants know that before the employer can alter the benefits provided by the terms of the plan, the employer must follow the proper procedure and make the changes to the plan in writing. Until this occurs, the participant is entitled to rely on the plan document's terms as written.

Benefits under a pension plan are subject to elaborate substantive protections in terms of benefit accrual and vesting.<sup>320</sup> Once accrued, benefits generally cannot be eliminated by a subsequent plan amendment.<sup>321</sup> Similar statutory protections do not apply to the benefits provided by welfare plans, particularly health care plans.<sup>322</sup> Consequently, claims challenging the employer's amendment procedure usually are much more significant in the context of health care plans. In effect, a claim of an improper amendment procedure serves as a way for the plan's participants indirectly to challenge the employer's amendment.

*Curtiss-Wright Corp. v. Schoonejongen*<sup>323</sup> illustrates a Category II claim under Section 402(b)(3) based on an alleged improper amendment procedure. In *Curtiss-Wright*, the employer for many years sponsored a health care plan (the "retiree health plan") for retired workers previously employed at certain manufacturing facilities of the employer. In 1983, the terms of the summary plan description for the retiree health plan were revised to state clearly that if operations at one of the plan's facilities were terminated, benefits under the plan for retirees from that facility also would be terminated. The plan document itself did not contain this language, but did state that "[t]he Company reserves the right at any time and from time to time to modify or amend, in whole or in part, any or all of the provisions of the Plan."<sup>324</sup>

Shortly after revising the summary plan description, the employer announced that one of the facilities would close. A company officer wrote to retirees of the closing facility and informed them that their benefits under the retiree health plan would be terminated. The retirees sued to block the termination of

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319. See *id.*, 1974 U.S.C.C.A.N. at 5077-78.

320. See 29 U.S.C. § 1053 (2000).

321. See 29 U.S.C. § 1054(g) (2000). Some optional forms of accrued benefits may, under limited circumstances, be eliminated. See *id.*

322. See 29 U.S.C. § 1051(1) (2000) (excluding welfare benefit plans from coverage under part 2 of title I of ERISA).

323. 514 U.S. 73 (1995).

324. *Id.* at 76.

their benefits. First, the retirees argued that the plan document language quoted above failed to state an amendment procedure as required by Section 402(b)(3). Second, the retirees argued that, even if the plan document language was sufficient to satisfy Section 402(b)(3), the employer failed to follow the amendment procedure described in the plan document. The retirees requested as a remedy under Section 502(a)(3) the retroactive restoration of their benefits under the retiree health care plan. The district court estimated the dollar value of these retiree benefits at \$2,681,086.

Twelve years after the termination of the retirees' benefits, the Supreme Court heard the case. The Supreme Court resolved the retirees' first claim by holding that the plan document language was sufficient under Section 402(b)(3). The Supreme Court remanded the case on the retirees' second claim, stating:

Having determined that the [retiree health] plan satisfies § 402(b)(3), *we do not reach the question of the proper remedy for a § 402(b)(3) violation*. On remand, the Court of Appeals will have to decide the question that has always been at the heart of this case: whether [the employer's] valid amendment procedure – amendment “by the Company” – was complied with in this case. The answer will depend on a fact-intensive inquiry, under applicable corporate law principles, into what persons or committees within [the employer] possessed plan amendment authority . . . .<sup>325</sup>

As the first line of this quotation makes clear, the Supreme Court deliberately did not reach the question of what remedy might be available for a violation of Section 402(b)(3). Under these circumstances the only statutory provision that authorizes a claim against the employer (here, acting in its nonfiduciary settlor capacity) is Section 502(a)(3). Thus, the remedy for an improper amendment procedure, whether it is in the form of a flawed plan document that fails the statutory requirements of Section 402(b)(3), or in the form of an employer who fails to follow the plan's stated amendment procedure, would be the remedy provided under Section 502(a)(3).

c. Category III: Breach of Fiduciary Responsibilities (Including Wrongfully Denied Claims for Plan Benefits)

Breach of fiduciary duty claims under Section 502(a)(3) cover the broadest range of claims under the modeling exercise. This result is consistent with the history and purpose of ERISA, which Congress enacted primarily in response to the need for greater federal regulation of fiduciary conduct.<sup>326</sup> In carrying out its

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325. *Id.* at 85 (emphasis added).

326. See H.R. REP. NO. 93-533, (1973), *reprinted in* 1974 U.S.C.C.A.N. at 4639, 4645-46; S. REP. NO. 93-127 (1973), *reprinted in* 1974 U.S.C.C.A.N. at

duties, a fiduciary with respect to a plan is subject to numerous requirements found in part 4 of title I of ERISA.<sup>327</sup> The primary requirements are contained in Sections 404(a) and 405.<sup>328</sup> These fiduciary and co-fiduciary duties are supplemented by an additional set of restrictions, the prohibited transaction rules, that prohibit a fiduciary from engaging or causing the plan to engage in certain transactions, or from holding certain assets.<sup>329</sup> Fiduciaries also are charged with additional responsibilities found outside of part 4 of title I, such as ensuring compliance with the reporting and disclosure rule of part 1 of title I of ERISA,<sup>330</sup> and following the administrative procedures for reviewing denied benefit claims described in Section 503 of ERISA.<sup>331</sup>

*i. Claims for Individual Monetary Relief for Breach of Fiduciary Responsibilities*

A threshold issue for any Category III claim is whether the claim properly lies under Section 502(a)(2) or Section 502(a)(3).<sup>332</sup> Explicit judicial recognition of the payee principle, described previously in Part III.C.2.b. of the Article, will shift a significant number of breach of fiduciary duty claims to Section 502(a)(2). Nevertheless, claims where the breach of fiduciary duty results in a loss of plan benefits that cannot be remedied by a restorative payment to the plan's trustee will still arise, such as where the benefits "lost" are payments due under an insurance policy.<sup>333</sup>

*Strom v. Goldman, Sachs & Co.*<sup>334</sup> illustrates a claim for individual monetary relief that is properly brought under Section 502(a)(3). In *Strom*, the participant completed the paperwork necessary to apply for a \$1,000,000 death benefit under the terms of the employer's life insurance plan. The plan's administrator delayed forwarding the paperwork in a timely manner to the insurance company, resulting in a one-month delay of the participant's effective date of coverage under the plan. Unfortunately, the participant suddenly died before his coverage began under the plan, thereby leaving his widow ineligible for the plan's \$1,000,000 death benefit. The insurance company was not

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4838, 4847; H.R. REP. NO. 93-1280, pt. V (1973), reprinted in 1974 U.S.C.C.A.N. at 5038, 5075-87. Unlike the fiduciary duties imposed on trustees under the common law, an individual cannot waive ERISA's fiduciary duties. See 29 U.S.C. § 1110(a) (2000) (declaring exculpatory clauses void as against public policy).

327. 29 U.S.C. §§ 1101-1113 (2000).

328. 29 U.S.C. §§ 1104-1105.

329. See 29 U.S.C. §§ 1106(a)-(b), 1107.

330. 29 U.S.C. § 1021 (2000).

331. 29 U.S.C. § 1133 (2000).

332. See discussion *supra* Part III.C.2.b.

333. See discussion *supra* Part II.A.3.

334. 202 F.3d 138 (2d Cir. 1999).



liable for payment under the terms of the policy because coverage under the policy had not yet commenced. The only option for the participant's widow was to bring a claim for breach of fiduciary duty against the negligent plan administrator under Section 502(a)(3). The Second Circuit in *Strom* awarded monetary relief to the widow based on a theory of make-whole relief.<sup>335</sup>

*Griggs v. E.I. Dupont de Nemeurs & Co.*<sup>336</sup> illustrates another set of circumstances where individual monetary relief under Section 502(a)(3) may be necessary to remedy a breach of fiduciary duty. In *Griggs*, the participant elected to receive a lump sum distribution from the plan instead of an annuity because the plan administrator erroneously informed the participant that the lump sum distribution qualified for a tax-deferred direct rollover.<sup>337</sup> As a result, the participant paid \$58,000 in income taxes on his lump sum distribution, leaving him with a net benefit of \$74,627.<sup>338</sup>

The district court concluded that the Supreme Court's prior decision in *Mertens* precluded a monetary remedy under Section 502(a)(3). The Fourth Circuit reversed, and ultimately approved a complicated remedy involving the partial rescission of the participant's lump sum distribution election.<sup>339</sup> The Fourth Circuit's remedy permitted the participant to repay the net benefit amount he had received back to the plan and re-elect the annuity payment option. The participant's net distribution amount (\$74,627), rather than his original pre-tax benefit amount (\$132,900), determined the monthly annuity benefit. Under this partial rescission remedy, the participant had the option to file an amended tax return and try to recover his additional income tax payment attributable to the original distribution election.<sup>340</sup>

What the Fourth Circuit attempted to do in *Griggs* was to make the participant as "whole" as possible for the plan administrator's breach of fiduciary duty. The better approach would be to permit a straightforward monetary award calculated to restore the participant's benefits that were "lost" due to the payment of additional income taxes that could have been avoided if the participant had received accurate information at the outset concerning the tax consequences of his distribution election decision.

*ii Claims Involving a Breach of the Duty to Inform*

Much of the increased volume in breach of fiduciary duty claims under Section 502(a)(3) is a direct result of the Supreme

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335. *Id.* at 150.

336. 385 F.3d 440 (4th Cir. 2004).

337. *Id.* at 443.

338. *Id.* at 442.

339. *Id.* at 445-49.

340. *Id.* at 452.

Court's 1996 decision in *Varity Corporation v. Howe*.<sup>341</sup> Before *Varity*, it was unclear whether a fiduciary's violation of ERISA's rules governing fiduciary conduct that resulted in harm to an individual plan participant, rather than injury to the plan itself, could form the basis for a breach of fiduciary duty claim under Section 502(a)(3). *Varity* answered this question affirmatively, and in the process spawned a new generation of breach of fiduciary duty claims based not on the misuse of plan assets by the fiduciary, but rather on the fiduciary's duty to provide relevant information to individual plan participants beyond the statutory reporting and disclosure requirements contained in part 1 of title I of ERISA.<sup>342</sup> Because by definition the fiduciary's duty to inform does not involve the fiduciary's mismanagement of the plan's assets, but instead is concerned with the fiduciary's communications (or lack thereof) with an individual plan participant, a claim for relief for an alleged breach of this fiduciary duty can only be brought under Section 502(a)(3).

Duty to inform cases are based on the premise that if the participant had received the appropriate information from the fiduciary, the participant would have made a different decision that would have resulted in more or better plan benefits, or could have selected an option that would have better suited the participant's individual circumstances. *Griggs* illustrates how the duty to inform may arise in the context of a pension plan distribution election decision. *Eddy v. Colonial Life Insurance Co.*<sup>343</sup> illustrates how the duty to inform may arise in the context of

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341. 516 U.S. 489 (1996).

342. The District of Columbia Circuit Court of Appeals was the first federal circuit to recognize the fiduciary's so-called "duty to inform" as part of a fiduciary's general duty of prudence under ERISA Section 404(a)(1)(B), 29 U.S.C. § 1104(a)(1)(B). See *Eddy v. Colonial Life Ins. Co.*, 919 F.2d 747, 750-51 (D.C. Cir. 1990). Since *Eddy*, the Second, Third, Fifth, Sixth, Seventh, Eighth, and Ninth Circuit Courts of Appeals appear to have recognized the duty to inform in various forms. See generally *Becker v. Eastman Kodak Co.*, 120 F.3d 5, 8 (2d Cir. 1997); *Bixler v. Central Pa. Teamsters Health & Welfare Fund*, 12 F.3d 1292, 1300 (3d Cir. 1993); *Switzer v. Wal-Mart Stores, Inc.*, 52 F.3d 1294, 1299 (5th Cir. 1995); *Shea v. Esensten*, 107 F.3d 625, 629 (8th Cir. 1997); *Barker v. American Mobile Power Corp.*, 64 F.3d 1397, 1403 (9th Cir. 1995).

The duty to inform imposes an affirmative duty upon the plan fiduciary to disclose all material facts or other information to the plan participant in response to participant questions. This duty includes an affirmative duty to speak up when the plan fiduciary knows that silence itself might be misleading. The plan fiduciary must convey complete and accurate information that is material to the participant's circumstances, even if the participant has not made a specific inquiry concerning such information. *MEDILL*, *supra* note 247, at 422-26. The duty to inform arises in numerous factual contexts. See Howard Shapiro & Robert Rachal, *The Duty to Inform and Fiduciary Breaches: The "New Frontier" in ERISA Litigation*, 14 LAB. LAW. 503-24 (1999) (addressing the developing duty to inform imposed by

a health care plan. In *Eddy*, the plan participant received a memo from his employer less than one week before a previously scheduled surgery informing him that the company had terminated its group health care plan. Consequently, the participant personally was responsible for paying the expenses of his upcoming surgery. The participant called the plan's administrator and inquired about his health insurance coverage. The plan administrator failed to inform the participant that he had the contractual right to convert his group plan coverage into an individual insurance policy. As a result, the participant incurred several thousand dollars in medical expenses that the individual insurance policy would have covered if the plan administrator had informed the participant of the contractual conversion option.<sup>344</sup>

*iii. Claims Involving Statutory Reporting and Disclosure Requirements*

The scope of the fiduciary's duty to inform overlaps with, but potentially reaches beyond, the statutory requirements of notice, reporting and disclosure imposed on the plan administrator by part 1 of title I of ERISA.<sup>345</sup> The legislative history of ERISA indicates Congress believed a lack of adequate information concerning the design, operation and assets of employee benefit plans played a significant role in the pre-ERISA problem of fiduciary misuse of plan assets.<sup>346</sup> Congress found that inadequate information provided to plan participants often unfairly deprived them of promised plan benefits.<sup>347</sup> The notice, reporting and disclosure requirements found in part 1 of title I of ERISA are based on the premise that if participants have adequate information, they can more effectively enforce their rights under the plan and deter fiduciary misconduct. Congress built upon the underlying philosophy of ERISA's reporting and disclosure

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ERISA in various settings).

343. 919 F.2d 747 (D.C. Cir. 1990).

344. *See id.* at 749.

345. *See* 29 U.S.C. §§ 1021-25 (2000).

346. *See* H.R. REP. NO. 93-533 (1973), *reprinted in* 1974 U.S.C.C.A.N. at 4639, 4645-46.

347. Congress determined that:

[i]t is grossly unfair to hold an employee accountable for acts which disqualify him from benefits, if he had no knowledge of these acts, or if these conditions were stated in a misleading or incomprehensible manner in plan booklets. Subcommittee findings were abundant in establishing that an average plan participant, even where he has been furnished an explanation of his plan provisions, often cannot comprehend them because of the technicalities and complexities of the language used.

*Id.* at 4646.

requirements when it later enacted parts 6 and 7 of title I of ERISA. These statutory sections contain similar notice and disclosure requirements that are unique to the administration of health care plans.<sup>348</sup>

Compliance with the statutory notice, disclosure and reporting requirements of parts 1, 6 and 7 of title I of ERISA is part of the plan administrator's duty of prudence under Section 404(a)(1)(B).<sup>349</sup> One component of the plan administrator's fiduciary responsibility in operating the plan is to ensure that these statutory requirements are satisfied. The plan administrator's failure to comply with one of these statutory requirements does not give rise to a separate category of claim under Section 502(a)(3). Rather, the violation of these statutory requirements properly is conceptualized as a particular subset of Category III claims for breach of fiduciary duty.

A claim challenging a defective summary plan description ("SPD") provided by the plan administrator illustrates this particular subset of Category III claims. ERISA Section 102 of ERISA<sup>350</sup> ("Section 102") requires that the plan administrator must provide a SPD document to plan participants that "shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants. . . of their rights and obligations under the plan."<sup>351</sup> In essence, Section 102 creates a federal statutory standard for the readability and accuracy of the SPD document.

The federal courts have long struggled with how to reconcile the statutory standard for the readability and accuracy of the SPD document under Section 102(a) with the written plan document rule of Section 402.<sup>352</sup> To resolve this dilemma, the lower federal courts have developed an elaborate set of rules based on the factual distinctions between: (1) SPDs that directly conflict with the provisions of a plan document; (2) SPDs that are silent on the point of information at issue, but the language of the plan document is clear; or (3) SPDs that are silent on the point of information at issue, and the language of the plan document is silent or ambiguous.<sup>353</sup> A silent or ambiguous plan document or SPD, supplemented by a misleading or inaccurate oral statement by the plan administrator, forms yet a fourth situation. In this fourth situation, the appropriate claim is still one for breach of

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348. See 29 U.S.C. §§ 1161-69; 1171-85b (2000); U.S. DEPT OF LABOR, *supra* note 300.

349. 29 U.S.C. § 1104(a)(1)(B) (2000).

350. 29 U.S.C. § 1022(a).

351. 29 U.S.C. § 1022(a).

352. 29 U.S.C. § 1102 (2000).

353. See MEDILL, *supra* note 247, at 72-77.

fiduciary duty, but the duty would be the fiduciary's duty not to misinform the participant by an oral statement.<sup>354</sup>

Rather than relying upon a federal common law claim of equitable estoppel,<sup>355</sup> the better conceptualization is to treat claims involving flawed SPDs as part of a particular subset of Category III claims. The appropriate theory is that the plan administrator has breached the fiduciary duty of prudence.<sup>356</sup> A flawed SPD gives rise to a breach of fiduciary duty claim based upon the plan administrator's imprudent actions in failing to comply with the statutory criteria for a readable and accurate SPD under Section 102(a).

*iv. Breach of Fiduciary Responsibility Claims Involving Other Statutory Requirements*

Title I of ERISA contains other statutory requirements with which a fiduciary must comply. These statutory requirements are directly related to the administration and operation of the plan and are imposed, expressly or implicitly, on the plan's administrator. Compliance with these other statutory requirements is properly conceptualized as part of the plan administrator's duty of prudence under Section 404(a)(1)(B). Thus, a violation of one of these other statutory requirements does not give rise to a separate category of claim under Section 502(a)(3), but rather is a particular subset of Category III claims for breach of fiduciary duty.

Section 402(a)'s written plan document rule illustrates this particular subset of breach of fiduciary duty claims. Under Section 402(a), the plan must be "established and maintained" pursuant to a written plan document.<sup>357</sup> Clearly, one cannot avoid regulation under title I of ERISA simply by maintaining an oral plan – ERISA's requirements will still be applied even if a written plan document does not exist.<sup>358</sup> Nevertheless, Section 402(a)'s requirement of a written plan document is central to the plan administrator's task of administering the plan. Knowingly administering an oral plan in the face of this statutory requirement is properly conceptualized as a breach of the plan administrator's fiduciary duty of prudence under Section 404(a)(1)(B).

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354. *See id.*

355. *See infra* Appendix A.

356. *See* 29 U.S.C. § 1104(a)(1)(B) (2000).

357. 29 U.S.C. § 1102(a).

358. *See* *Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982).

*v. Claims for a Violation of the Prohibited Transaction Rules by a Fiduciary*

Part III.B.4 of the Article previously described the two ways a fiduciary could violate the prohibited transaction rules of ERISA. An authorizing fiduciary could cause the plan to engage in a prohibited transaction.<sup>359</sup> Alternatively, a fiduciary personally could engage in a transaction involving plan assets that is prohibited under the fiduciary prohibited transaction rules of Section 406(b).<sup>360</sup> Rather than characterizing these violations of the prohibited transaction rules by a fiduciary as giving rise to a separate category of claims, the better conceptualization is to treat these claims as a particular subset of Category III claims for breach of fiduciary duty.

This characterization applies when the defendant who authorized or engaged in the prohibited transaction is a fiduciary. When the defendant is a nonfiduciary party in interest or a third party with respect to the plan, the claim is properly characterized as either a Category V claim<sup>361</sup> or a Category VI claim,<sup>362</sup> respectively.

*vi. Claims Involving a Wrongful Denial of Plan Benefits*

The justification for including wrongful denial of benefits claims as a subset of Category III claims is that the plan administrator has a statutory fiduciary duty to follow the terms of the plan under Section 404(a)(1)(D).<sup>363</sup> In *Varity Corporation v. Howe*,<sup>364</sup> the Supreme Court acknowledged the fiduciary duty implications of a claim for wrongfully denied benefits brought under Section 502(a)(1)(B).<sup>365</sup> The *Varity* opinion merely highlighted this issue rather than resolving it.<sup>366</sup> Since *Varity*, the lower federal courts have had no further guidance from the Supreme Court as to when additional relief under Section 502(a)(3) may be appropriate in situations where the federal court has determined that a plan administrator has wrongfully denied a participant's claim for plan benefits.

*Varity* can be read to support the conceptualization of a wrongful claim denial by the plan administrator as also giving rise to a breach of the plan administrator's duty under Section 404(a)(1)(D) to follow the terms of the plan.<sup>367</sup> Interpreting the

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359. See 29 U.S.C. § 1106 (2000) (introductory clause).

360. 29 U.S.C. § 1106(b).

361. See discussion *infra* Part III.C.3.e.

362. See discussion *infra* Part III.C.3.f.i.

363. See discussion *supra* Part III.C.2.a.

364. 516 U.S. 489 (1996).

365. See *id.* at 514-15.

366. See discussion *supra* Part III.C.2.a.

367. See discussion *supra* Part III.C.2.a.

statute in this fashion so as to authorize a *claim* for breach of fiduciary duty under Section 502(a)(3) does not, however, guarantee a *remedy* under Section 502(a)(3) for every instance in which a plan administrator has wrongfully denied a participant's claim for plan benefits. Later in Part III.D.3.d. of the Article, I take up the question of when a remedy under Section 502(a)(3), in addition to the remedy afforded by Section 502(a)(1)(B), would be "appropriate" in the context of a wrongfully denied claim for plan benefits.

d. Category IV: Violation of Plan Terms by Participants

Category IV claims differ from the other categories in that the alleged violation is not based on a statutory requirement of title I of ERISA, but on the terms of the employee benefit plan itself. Category IV claims are limited to defendants who are plan participants. If the person who violates a plan term is a fiduciary with respect to the plan, the proper claim against the defendant fiduciary would be a Category III claim for breach of the fiduciary's duty to follow the terms of the plan document under Section 404(a)(1)(D). If the defendant who violates a plan term is not a fiduciary with respect to the plan, but is either a party in interest or a third party, the proper claim against the defendant would be a Category V claim or a Category VI claim, respectively.<sup>368</sup> Category IV claims against plan participants do not overlap with Category V claims against parties in interest because the modeling exercise excludes plan participants from the class of party in interest defendants.<sup>369</sup> Similarly, Category III claims against fiduciaries do not overlap with Category V claims against parties in interest because the modeling exercise excludes fiduciaries from the class of party in interest defendants.<sup>370</sup>

*Great-West Life & Annuity Insurance Co. v. Knudson*<sup>371</sup> and *Sereboff v. Mid Atlantic Medical Services, Inc.*<sup>372</sup> illustrate a Category IV claim. In both *Great-West* and *Sereboff*, the terms of the employer's health care plan required that if a participant received medical care benefits under the plan for an injury caused by a third party tortfeasor, the participant had to reimburse the plan for such benefits if the participant later recovered against the third party tortfeasor who was responsible for causing the participant's injury.<sup>373</sup> In both cases, the plan participants recovered against the tortfeasors, but did not fully reimburse the plan.

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368. See discussion *infra* Parts III.C.3.e-f.

369. See discussion *supra* Part III.A.2.

370. See discussion *supra* Part III.A.2.

371. 534 U.S. 204 (2002).

372. 126 S. Ct. (2006).

373. *Great-West*, 534 U.S. at 207; *Sereboff*, 126 S.Ct. at 1872.

Claims for reimbursement also arise in the context of disability benefit plans. Disability plans typically provide that the amount of the monthly benefit payable by the plan is to be reduced or offset by Social Security disability benefit payments.<sup>374</sup> To make the participant's reimbursement obligation clear to the participant, the plan may even require the participant to execute an agreement stating that the participant will reimburse the plan in the event that the participant later receives a retroactive award of Social Security disability benefits.<sup>375</sup> Claims for reimbursement typically arise when the Social Security Administration retroactively pays disability benefits due as a lump sum award, and the participant refuses to reimburse the plan.

Disability plans with Social Security offset provisions usually provide that if the participant fails to reimburse the plan, the plan may suspend or reduce future disability benefit payments until the plan has been fully reimbursed. The federal courts generally have upheld the plan administrator's authority to suspend or reduce future disability benefit payments so as to recoup overpayments over time based on an equitable set-off theory.<sup>376</sup> The better practice would be for the federal courts also to permit the plan administrator to bring a claim under Section 502(a)(3) against the participant to enforce the Social Security offset provisions of the plan and compel immediate and full reimbursement.<sup>377</sup>

Mistaken overpayment cases provide a third illustration of a Category IV claim against a plan participant. The facts of *Ramsey v. Formica Corp.*<sup>378</sup> are typical of these mistaken overpayment cases. In *Ramsey*, the plan administrator miscalculated the benefit payment amounts due under the formula established by the terms of the plan. The overpayments to retired participants began in 1985, but were not discovered until many years later after an audit of the plan in 2003. In *Ramsey*, as in many of the mistaken overpayment cases, the retired participants had no

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374. See, e.g., *Coop. Benefit Adm'rs v. Ogden*, 367 F.3d 323, 325 (5th Cir. 2004); *Northcutt v. Gen. Motors Hourly-Rate Employees Pension Plan*, 2005 WL 2886211, \*1 (S.D. Ind. Oct. 31, 2005); *Butler v. Aetna U.S. Healthcare, Inc.*, 109 F. Supp. 2d 856, 857-58 (S.D. Ohio 1999).

375. See *Ogden*, 367 F.3d at 326; *Northcutt*, 2005 WL 2886211 at \*2.

376. See *Butler*, 109 F. Supp. 2d at 861 (listing numerous prior cases permitting recoupment by the plan of overpayments caused by a participant's receipt of a retroactive Social Security disability award).

377. Compare *Ogden*, 367 F.3d at 336 (stating that ERISA does not recognize a federal common law claim for reimbursement), with *Northcutt*, 2005 WL 2886211 at \*6 ("Plaintiff's lawsuit is premised on a novel interpretation of a recent Supreme Court decision in hopes that it will support their effort to prohibit defendants from reducing or suspending plan benefits to recoup overpayments. . . . The Court finds no basis on which to conclude that enforcement of the contractual provisions of the Pension Plan and the Disability Plan would violate ERISA policy or its statutory scheme.").

378. 398 F.3d 421 (6th Cir. 2005).



knowledge of the plan administrator's error in calculating the benefit amount.<sup>379</sup> In some cases, however, the participant has notice of the calculation error.<sup>380</sup> Prior to *Great-West*, the federal courts generally permitted the plan administrator to bring a claim against the participant to recover the overpayment amount.<sup>381</sup> After *Great-West* and *Sereboff*, the federal courts should continue to interpret Section 502(a)(3) as authorizing these claims based on the plan administrator's fiduciary obligation to enforce the terms of the plan, which limit the participant to a lesser benefit amount.<sup>382</sup>

It is important to reiterate that the above discussion has focused solely on the various types of Category IV *claims*. As with wrongfully denied claims for plan benefits, the issue of what *remedies* are "appropriate" under section 502(a)(3) for such claims is a difficult one. I address remedies issues later in Part III.D.3. of the Article.

#### e. Category V: Knowing Participation in Breach of Fiduciary Duties or Prohibited Transactions by Parties in Interest

Category V claims focus on the conduct of persons who are parties in interest<sup>383</sup> with respect to a plan. A Category V claim is typically brought against a person who is a party in interest by virtue of providing services for the plan administrator or the plan's sponsoring employer.<sup>384</sup>

Category V claims involve two types of misconduct by a party in interest. For both types of misconduct, the factual prerequisite to a Category V claim is the knowing breach or violation by a plan fiduciary of the fiduciary responsibility provisions found in part 4

379. See *id.* at 423; *Kaliszewski v. Sheet Metal Workers' Nat'l Pension Fund*, No. 03-216E, 2005 WL 2297309, \*3 (W.D. Pa. July 19, 2005); *Lumenite Control Tech., Inc. v. Jarvis*, 252 F. Supp. 2d 700, 702-03 (E.D. Ill. 2003); *Whitman v. Hawaiian Tug & Barge Corp./Young Bros., Ltd. Salaried Pension Plan*, 27 F. Supp. 2d 1225, 1228 (D. Haw. 1998).

380. *Tynan v. Am. Airlines, Inc. Pilot Ret. Benefit Program*, No. 04-cv-335, 2005 WL 2203172, \*4 (D.N.H. Sept. 9, 2005); *Iron Workers Tri-State Welfare Plan v. Jaraczewski*, No. 02-c-2596, 2002 WL 31854972, \*4 (N.D. Ill. Dec. 19, 2002).

381. *E.g., Jaraczewski*, 2002 WL 31854972, at \*3.

382. Compare *Tynan*, 2005 WL 2203172 at \*6 (permitting recoupment claim on equity principles), with *Kaliszewski*, 2005 WL 2297309, at \*4-\*7 (relying on *Great-West* to deny summary judgment against participant on plan administrator's claim to recoup overpayments).

383. Recall that as part of the modeling exercise parties in interest as defendants were defined to exclude persons who are fiduciaries or employees who are plan participants. See discussion *supra* Part III.A.1.

384. See 29 U.S.C. § 1002(14)(B) (2000) (defining "party in interest" to include a person providing services to a plan).

of title I of ERISA.<sup>385</sup> The party in interest may knowingly participate in a fiduciary's breach of duty. This type of Category V claim, which was predicted by the modeling exercise, has been previously suggested as theoretically possibly by Professor Susan Stabile<sup>386</sup> based on the Supreme Court's analysis and reasoning in *Harris Trust and Savings Bank v. Salomon Smith Barney, Inc.*<sup>387</sup> A Category V claim also may be brought against a party in interest who knowingly engages in a prohibited transaction involving plan assets. This type of Category V claim was recognized explicitly by the Supreme Court in *Harris Trust* as authorized by Section 502(a)(3).<sup>388</sup>

The statutory provision that underlies both types of Category V claims is Section 502(l) of ERISA.<sup>389</sup> Congress added Section 502(l), which is a civil money penalty provision, to ERISA in 1989.<sup>390</sup> Section 502(l)(1) states:

In the case of—

(A) any breach of fiduciary responsibility under (or other violation of) part 4 by a fiduciary, or

(B) any knowing<sup>391</sup> participation in such a breach or violation by any other person,

the Secretary shall assess a civil penalty against such fiduciary or

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385. 29 U.S.C. §§ 1101-1113 (2000).

386. Stabile, *supra* note 121, 5 EMP. RTS. & EMP. POL'Y J. at 154.

387. 530 U.S. 238, 242 (2000).

388. *Id.* at 245.

389. 29 U.S.C. § 1132(l) (2000).

390. Congress added Section 502(l) to ERISA in Section 2101 of the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 2101, 103 Stat. 2106 ("OBRA '89"); see 55 Fed. Reg. 25288 (June 20, 1990). Department of Labor regulations implementing Section 502(l) are codified at 29 C.F.R. § 2570.80-.88. Although Congress made Section 502(l) effective for violations occurring on or after December 19, 1989, see Pub. L. No. 101-239, § 2101(c), under the Department of Labor's "continuing violations" interpretation of the statute a penalty can be assessed on conduct that predates the enactment of the statute. See 55 Fed. Reg. 25288, 25288-89 & nn.5-8 (June 20, 1990).

391. Section 502(l) assesses a civil money penalty only if the other person "knowingly" participates in the fiduciary's breach or violation of a statutory provision found in part 4 of title I of ERISA. As interpreted by the Supreme Court in *Harris Trust*, "knowledge" by the party in interest is actual or constructive knowledge.

Only a transferee of ill-gotten trust assets may be held liable, and then only when the transferee (assuming he has purchased for value) knew or should have known of the existence of the trust and the circumstances that rendered the transfer in breach of the trust. Translated to the instant context, the transferee must be demonstrated to have had *actual or constructive knowledge* of the circumstances that rendered the transaction unlawful.

See *Harris Trust*, 530 U.S. at 251 (emphasis added).

other person in an amount equal to 20 percent of the applicable recovery amount.<sup>392</sup>

Section 502(l)(2) defines the “applicable recovery amount” (used to calculate the 20 percent penalty amount referenced above) as follows:

For purposes of paragraph (1), the term “applicable recovery amount” means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1)—

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection [502](a)(2) or [502](a)(5).<sup>393</sup>

The statutory language of Section 502(a)(5) is virtually identical to Section 502(a)(3), thereby permitting the Secretary of Labor to seek exactly the same type of relief that a private plaintiff may seek under Section 502(a)(3).<sup>394</sup> It is this parallel structure between Sections 502(a)(5) and 502(a)(3) that, according to the Supreme Court’s analysis in *Harris Trust*, justifies Category V claims as authorized by the statutory language of ERISA.<sup>395</sup>

Standing alone, Section 502(l) appears to present a curious basis for authorizing claims under Section 502(a)(3) against a party in interest. After all, Section 502(l) was not added to title I of ERISA until 1989, long after Section 502(a)(3) was enacted.<sup>435</sup> Moreover, Section 502(l) is a civil money penalty provision that can only be enforced by the Secretary of Labor, not by a private civil plaintiff.<sup>397</sup> Nevertheless, *Harris Trust* was a 9-0 decision by the Supreme Court. Such unanimity suggests that the Justices firmly believed that the plan fiduciary’s claim in *Harris Trust* against the party in interest who engaged in a prohibited transaction was authorized by Section 502(a)(3) based on Section 502(l).<sup>398</sup>

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392. 29 U.S.C. § 1132(l)(1)(emphasis added).

393. 29 U.S.C. § 1132(l)(2)(emphasis added).

394. Compare 29 U.S.C. § 1132(a)(3) (2000) with 29 U.S.C. § 1132(a)(5) (2000).

395. As the Supreme Court explained in *Harris Trust*, if the Secretary may bring suit against an “other person” under subsection [502](a)(5), it follows that a participant, beneficiary, or fiduciary may bring suit against an “other person” under the similarly worded subsection [502](a)(3). *Harris Trust & Sav. Bank v. Salomon Smith Barney*, 530 U.S. 238, 248-49 (2000).

396. See note 390.

397. See 29 U.S.C. § 1132(l) (2000).

398. The *Harris Trust* Court succinctly described its reasoning in the following terms.

Although not mentioned by the Supreme Court in *Harris Trust*, there is a procedural provision in Section 502 that further supports the Supreme Court's conclusion. Under Section 502(h) of ERISA,<sup>399</sup> ("Section 502(h)") a private plaintiff who brings an action for any violation of title I of ERISA (other than a claim for denied benefits under Section 502(a)(1)(B)) is required to provide a copy of the complaint to the Department of Labor. The purpose of this provision is to give the Secretary of Labor notice and opportunity to intervene in the case. If the Secretary decides to intervene in private litigation where the plaintiff's claim is brought under Section 502(a)(3), then the Secretary's claim must be brought under Section 502(a)(5). It would be a strained reading of the parallel statutory language of Sections 502(a)(3) and 502(a)(5) to permit the Secretary of Labor, as intervenor in the plaintiff's case, to bring additional claims under Section 502(a)(5) against the defendant that the original plaintiff could not bring under Section 502(a)(3).

Thus far, my discussion of Category V claims against a party in interest has been limited to situations where the statutory elements of Section 502(l) are satisfied. These requirements are discussed in detail in the next part of the Article concerning Category VI claims against third parties.<sup>400</sup>

It is possible for a claim to be brought against a party in interest where the statutory elements of Section 502(l) are not satisfied. The analysis of a claim against a party in interest that is outside the scope of Section 502(l) is identical to the analysis for such a claim against a third party defendant. Again, to avoid repetition, I discuss claims that are outside the scope of Section 502(l) in the next part of the Article concerning Category VI claims against third parties.

#### f. Category VI: Claims Against Third Parties

Category VI claims against unrelated third parties are based on the common characteristic that the defendant is a person who does not have a relationship with an employee benefit plan that is recognized by the statutory definitions contained in Section 3.<sup>401</sup> In this sense, Category VI claims are the only true "catch-all" category of claims under Section 502(a)(3).

The modeling exercise predicted several claims for Category

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In ERISA cases, "as in any case of statutory construction, our analysis begins with the language of the statute. . . . And where the statutory language provides a clear answer, it ends there as well." Section 502(a)(3), as informed by § 502(l), satisfied this standard.

*Harris Trust*, 530 U.S. at 254.

399. 29 U.S.C. § 1132(h) (2000).

400. See discussion *infra* Part III.C.3.f.

401. See discussion *supra* Part III.A.1.

VI that, based on my research, have not yet appeared before the federal courts. For purposes of analysis, Category VI claims are divided into two types: (1) claims against third parties based on the statutory elements of Section 502(l); and (2) claims against third parties that are outside the scope of Section 502(l). Each type of Category VI claim is discussed separately below.

*i. Third Party Defendant Claims Based on Section 502(l)*

Section 502(l) provides a statutory basis for the first type of Category VI claims against third party defendants because the term "other person" is sufficiently broad to include unrelated third parties.<sup>402</sup> Section 502(l) suggests two elements for a claim that may be brought under Section 502(a)(3) against a third party. First, a plan fiduciary must have breached or otherwise violated a statutory responsibility described in part 4 of title I of ERISA. Here, the most likely possibilities are a breach of fiduciary duty,<sup>403</sup> a breach of a co-fiduciary duty,<sup>404</sup> or a violation of the prohibited transaction rules.<sup>405</sup> Second, the third party must have had actual or constructive knowledge of the fiduciary's breach or violation at the time the third party participated in the breach or other violation by the fiduciary.<sup>406</sup>

An illustration of a Category VI claim that fits squarely within the statutory elements of Section 502(l) is a claim by the plan administrator to recover plan benefits that were paid to a third party—a stranger to the plan—by mistake. In this type of mistaken payment case, the administrative error clearly is a breach of the administrator's fiduciary duty of prudence. This breach of fiduciary duty satisfies the first element for a claim based on Section 502(l). The second element of Section 502(l) also is satisfied because the third party who receive the payment has, at a minimum, constructive knowledge of the plan administrator's error and knowingly participates in the administrator's breach of fiduciary duty by accepting the payment. Although the third party may not know all of the details of the plan administrator's breach of fiduciary duty, the third party recipient of the payment certainly should know that money does not magically fall from the sky in the form of a payment from an employee benefit plan.

The Supreme Court's opinion in *Harris Trust*<sup>407</sup> suggests a second illustration of a Category VI claim based on the statutory elements of Section 502(l). In *Harris Trust*, the Court suggested

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402. See 29 U.S.C. §§ 1132(l)(1)(B) (2000); § 1002(9) (2000) (defining person).

403. 29 U.S.C. § 1104(a)(1)(2000).

404. 29 U.S.C. § 1105 (2000).

405. 29 U.S.C. § 1106 (2000).

406. See *supra* note 391.

407. *Harris Trust & Sav. Bank v. Salomon Smith Barney*, 530 U.S. 238 (2000).

that a Section 502(a)(3) claim could be brought against a subsequent transferee of plan assets that are tainted by a prior prohibited transaction.<sup>408</sup> Although the facts of *Harris Trust* involved a party in interest defendant as the first transferee of the plan assets at issue, one can easily imagine a scenario where a party in interest, who has purchased plan assets in violation of the prohibited transaction rules, subsequently transfers the plan assets to a third party. If the plan fiduciary later seeks to rescind the transaction as a violation of the prohibited transaction rules, and the plan assets are unique (as in the case of real property), the plan fiduciary may want to assert a claim for rescission against the third party under Section 502(a)(3). To prevail on a rescission claim, the plan fiduciary must show that the third party knew that the assets were tainted as the subject of a prior prohibited transaction. This knowledge requirement will be satisfied where the defendant party in interest has a prearranged understanding with the third party to transfer the assets from the plan as part of a prohibited transaction.

In cases of collusion, permitting the plan fiduciary to bring a Category VI claim against a third party who holds assets that were the subject of a prohibited transaction serves an important deterrence and enforcement function. Conversely, not permitting a claim against the third party under Section 502(a)(3) in this type of collusion situation would significantly undermine the purpose and function of the prohibited transaction rules.

*ii. Third Party Defendant Claims Beyond the Scope of Section 502(l)*<sup>409</sup>

There are circumstances where the plaintiff's claim may not satisfy the two statutory elements of Section 502(l). This possibility raises the question of whether Section 502(l) *limits* the language of Section 502(a)(3) when the defendant is a third party, or whether Section 502(a)(3) *itself imposes a duty* on third parties and simultaneously authorizes such a claim.<sup>410</sup>

One such situation arises where the plan administrator innocently makes a payment from the plan to or for the benefit of a third party based on the fraudulent misrepresentations made by a

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408. See *Harris Trust*, 530 U.S. at 251 (quoting *Moore v. Crawford*, 130 U.S. 122, 128 (1889)) (“[A] court of equity has jurisdiction to reach the property either in the hands of the original wrongdoer, or in the hands of any subsequent holder, until a purchaser of it in good faith and without notice acquires a higher right and takes the property relieved from the trust”).

409. For purpose of this discussion, the analysis of a third party defendant also applies to a defendant who is a party in interest.

410. *Harris Trust*, 530 U.S. at 245 (“[Section] 502(a)(3) itself imposes certain duties, and therefore...liability under that provision does not depend on whether ERISA’s substantive provisions impose a specific duty on the party being sued”).

plan participant.<sup>411</sup> Fraudulent misrepresentation cases illustrate most vividly why claims against third party defendants under Section 502(a)(3) should not be limited strictly to factual circumstances where the two statutory elements of Section 502(l) are satisfied. To date, the federal courts have resolved these cases by straining to find that the plaintiff plan administrator's state law claim of fraud<sup>412</sup> or restitution<sup>413</sup> against the third party was not preempted by Section 514(a).<sup>414</sup>

Why would a plaintiff plan administrator use a state law claim in these fraudulent misrepresentation cases, rather than bringing a claim under Section 502(a)(3) of ERISA? The likely reason is that the availability of such a claim under ERISA against a third party defendant is uncertain.<sup>415</sup> Fundamentally, however, the plaintiff's claim in these fraudulent misrepresentation cases is one to enforce the terms of the plan. When conceptualized in this fashion, such a claim *is* authorized by the plain language of Section 502(a)(3). Instead of forcing plan administrators to rely on the vagaries of state law to recover fraudulently induced payments, the better judicial interpretation is to characterize these claims against third parties as expressly authorized by Section 502(a)(3) as claims to enforce the plan terms of the plan.

Another situation that lies outside the scope of Section 502(l) arises if a participant recovers against a tortfeasor who caused the participant's injury, but the participant refuses to reimburse the health care plan for the participant's medical expenses. The participant's attorney also may claim a portion of the funds

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411. See *Trustees of the AFTRA Health Fund v. Biondi*, 303 F.3d 765 (7th Cir. 2002) (describing a situation in which a participant misrepresented that ex-wife was his spouse); *Nat'l Benefit Adm'rs, Inc. v. Miss. Methodist Hosp. & Rehab. Ctr.*, 748 F. Supp. 459 (S.D. Miss. 1990) (describing a situation in which participant misrepresented son's age and student status for purposes of receiving benefits under dependent coverage).

412. See Langbein, *supra* note 13, at 1359, n. 249 (discussing how the *Biondi* court used a state law claim of fraud in order to reclaim plan assets).

413. See *Nat'l Benefit Adm'rs, Inc.*, 748 F. Supp. at 46.

414. 29 U.S.C. § 1144 (2000).

415. See *Biondi*, 303 F.3d at 782. In *Biondi*, the Second Circuit reasoned that:

[b]ecause ERISA does not provide *any* mechanism for plan administrators or fiduciaries to recoup monies defrauded from employee benefit trust funds by plan participants, garden-variety state-law tort claims must, as a general matter, remain undisturbed by ERISA; otherwise there would be no way for a trust fund to recover damages caused by a plan participant's fraudulent conduct. . . .

*Id.*; see also *Nat'l Benefit Adm'rs*, 748 F. Supp. at 464 (stating that "this area of the law has not been displaced by ERISA; it has not been displaced by the exclusive provisions of that statute because ERISA does not regulate it. It follows that if this area is not regulated by ERISA, no cause of action can arise therefrom").

recovered from the tortfeasor as attorney's fees.<sup>416</sup> If the amount of the tort recovery is insufficient to satisfy both the health care plan's claim for reimbursement and the attorney's claim for payment for legal services, a dispute over the priority of claims to the funds recovered may arise between the health care plan and the participant's attorney. If part of the proceeds has been disbursed to the participant's attorney, the attorney similarly may refuse to reimburse the plan.

A variation on this theme is suggested by the facts of *Great-West*,<sup>417</sup> where most of the tort recovery funds were paid to the trustee of a private express trust established for the benefit of the participant.<sup>418</sup> In a future case, the participant may transfer the funds recovered from the tortfeasor to the trustee of an express trust established for the benefit of the participant, or better yet, for the benefit of the participant's spouse or other family members. The objective of the transfer is, of course, to put the tort recovery funds out of the reach of the plan administrator.

In these situations, can the plan administrator enforce the terms of the plan's reimbursement clause by bringing a claim under Section 502(a)(3) against the attorney or the trustee? Another way of framing this question is to ask: does Section 502(l) *limit* the scope of claims possible under Section 502(a)(3) when the defendant is a third party?

The analytical difficulty with each of these scenarios is that a statutory element of Section 502(l) – misconduct by a plan fiduciary – is lacking. The better judicial interpretation of Section 502(a)(3) in each situation is that the universe of possible third party claims under Section 502(a)(3) should not be limited solely to situations where the two statutory elements of Section 502(l) are satisfied. The reasoning for this conclusion differs depending on whether it is a trustee or an attorney who holds the tort recovery funds.

The easier of the two scenarios is where a plan participant transfers all or part of his tort recovery to the trustee of an express trust. In this situation, the Supreme Court's opinion in *Sereboff*<sup>419</sup> suggests that an equitable lien attaches to the funds. The participant should not be able to shed this lien via a transfer of the tort recovery funds to the trust, just as under the common law the

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416. See *Bombardier Aerospace Employee Welfare Benefits Plan*, 354 F.3d 348, 361 (5th Cir. 2003); *Admin. Comm. Of the Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan v. Varco*, 338 F.3d 680, 692 (7th Cir. 2003); *Wal-Mart Stores Health and Welfare Plan v. Wells*, 213 F.3d 398, 403 (7th Cir. 2000); *Hotel Employees Int'l Union Welfare Fund v. Gentner*, 50 F.3d 719, 721-23 (9th Cir. 1995); *Greenwood Mills, Inc. v. Burris*, 130 F. Supp. 2d 949, 963 (M.D. Tenn. 2001).

417. *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. at 204 (2002).

418. *Id.* at 207-8.

419. *Sereboff v. Mid Atlantic Medical Servs. Inc.*, 126 S. Ct. 1869 (2006).



settlor of a trust could not defeat his creditors by transferring his own assets to a trust while retaining the benefit of those assets as a trust beneficiary.<sup>420</sup> Under these circumstances, the better interpretation is that Section 502(a)(3) permits the plan administrator to bring a claim directly against the third party trustee who holds the tort settlement funds.<sup>421</sup> This interpretation is consistent with the Supreme Court's statement in *Harris Trust* that "502(a)(3) itself imposes certain duties, and therefore...liability under that provision does not depend on whether ERISA's substantive provisions *impose a specific duty* on the party being sued."<sup>422</sup>

The justifications for interpreting Section 502(a)(3) as authorizing a claim against the participant's attorney are based on ERISA's statutory provisions concerning federal subject matter jurisdiction.<sup>423</sup> If the federal courts interpret Section 502(a)(3) as *not* authorizing a claim against a participant's attorney, plan administrators will be forced to aggressively intervene in state court tort actions in hopes of convincing the state court judge to enforce the terms of the plan's reimbursement clause as part of a tort settlement agreement or judgment. Leading employee benefits practitioners have criticized this development, which flows directly from the Supreme Court's opinion and reasoning in *Great-West*, as a costly litigation maneuver that may not always produce a satisfactory result for the plan.<sup>424</sup>

Fundamentally, what the plan administrator seeks to do by intervening in the participant's state court tort action is to *enforce the terms of the plan*. A claim to enforce the terms of an employee benefit plan is expressly authorized by the statutory language of Section 502(a)(3). It is the federal courts, not the state courts, that have *exclusive subject matter jurisdiction* over Section 502(a)(3) claims.<sup>425</sup> Section 502(a)(3) should not be interpreted by the federal courts in such a manner as to abrogate the exclusive subject matter jurisdiction of the federal courts by forcing plan administrators to intervene in state court tort proceedings to litigate their reimbursement claims.

Due to the uncertainty surrounding claims for reimbursement in the federal courts, plan administrators have turned to another technique to buttress their ability to enforce a reimbursement plan

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420. See RESTATEMENT (SECOND) OF TRUSTS § 156(1) (1959); GEORGE T. BOGERT, TRUSTS AND TRUSTEES, § 223, 446-51 (rev. 2d ed. 1992).

421. Moreover, any trust agreement terms that prohibit the trustee from distributing the funds held in the trust to the plan administrator in satisfaction of a claim for reimbursement should be viewed by the federal courts as preempted by ERISA. See 29 U.S.C. § 1144(a) (2000).

422. *Harris Trust*, 530 U.S. at 245 (emphasis added).

423. 29 U.S.C. § 1132(e)(1)(2000).

424. See sources cited *supra* note 96.

425. 29 U.S.C. § 1132(e)(1).

term through the state courts. This technique requires that the participant and any attorney who represents the participant must sign a contractual agreement directly with the plan agreeing that the plan's expenses shall be recovered first out of any eventual tort recovery.<sup>426</sup> Execution of this agreement is made a precondition to the plan's payment of any medical expenses incurred as a result of the participant's injuries. If the attorney later refuses to abide by the terms of the agreement, the plan administrator may bring a state law breach of contract claim in state court.<sup>427</sup>

This "manufactured" state law breach of contract claim brings to the forefront the role that another statutory provision—preemption of state law under Section 514(a)<sup>428</sup>—plays in determining the breadth of Category VI claims that fall outside of Section 502(l). If ERISA preemption extends to enforcement of the contractual agreement between the attorney and the plan, then a claim under Section 502(a)(3) becomes the only means of enforcing the plan's reimbursement terms. If, however, ERISA does not preempt state contract law in this situation, then such contractual arrangements may be enforced in the state courts using state law-based principles.<sup>429</sup>

The second outcome may appeal to those federal judges who desire to hear fewer cases involving ERISA. If the federal courts encourage the law to develop in this direction, the perceived judicial economy benefits for the federal courts are, in the long run, likely to prove illusory. Permitting contractual reimbursement agreements to be enforced via state law contract claims in state courts is unsound because it creates a split federal-state forum for resolution of the underlying dispute. The contractual reimbursement agreement is based on the terms of the plan. Moreover, the cooperation of the plan participant may be required to enforce the agreement's terms. Even if the state court rules against the attorney on the breach of contract claim, the federal courts still retain exclusive subject matter jurisdiction under Section 502(e)(1) to enforce the reimbursement clause of the plan against the participant as a claim brought under Section 502(a)(3).

Permitting enforcement of contractual reimbursement

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426. See Robert N. Eccles & David E. Gordon, *Great-West Life VII*, 12 ERISA LIT. REP. (Glasser Legal Works) at 1 (April 2004) (describing this technique); *Kress v. Food Employers Labor Relations Ass'n*, 391 F.3d 563, 565 (4th Cir. 2004) (stating that the plan refused to pay participant's claim for benefits because participant's attorney refused to execute subrogation agreement).

427. This technique was the subject of the litigation in *Providence Health Plan v. McDowell*, 385 F.3d 1168 (9th Cir. 2004).

428. 29 U.S.C. § 1144(a) (2000).

429. See *Providence Health Plan*, 385 F.3d at 1168, 1173 (holding that the plan administrator's state law contract claim for reimbursement was not preempted by ERISA).

agreements against an attorney through state law contract claims in state courts also is unsound policy. Such an approach is likely to prove administratively costly and burdensome, particularly for employers who operate in more than one jurisdiction. Over time, different state courts are likely to come up with different interpretations of the same health care plan's contractual reimbursement agreement—exactly the sort of problem that ERISA's statutory preemption provision was designed to address.<sup>430</sup> Tailoring the terms of each contractual reimbursement agreement to suit the contracts law of each state would lead to more complex and more costly plan administration at a time when employers and employees are struggling with the rising costs of health care plan benefits.

*iii. Section 514(a) As "Flood Control" for Claims Against Third Parties*

The above discussion should not be read as dismissive of the significant role of state law in defining the scope of Category VI claims against third parties that are outside the scope of Section 502(l). Indeed, the possibility of an alternative viable claim under state law should be a crucial factor when a federal court must decide whether a claim against a third party that is outside the scope of Section 502(l) may be brought under Section 502(a)(3). In this sense, the federal judiciary may control the proverbial "floodgates" of third party claims under Section 502(a)(3) through a reasonable and measured interpretation of the scope of ERISA preemption of state law claims under Section 514(a).

As articulated by the Supreme Court in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*,<sup>431</sup> the starting point for analysis is the presumption that state law claims against third parties are not preempted by title I of ERISA. But when there are compelling policy justifications under ERISA, such as assuring uniformity of plan interpretation and administration, the federal courts should view a competing state law claim as preempted, and interpret Section 502(a)(3) as authorizing a claim against the third party defendant.

*4. Summary of the Six Categories of Claims*

A picture is worth a thousand words. The diagram below provides a helpful summary of the results of the modeling exercise

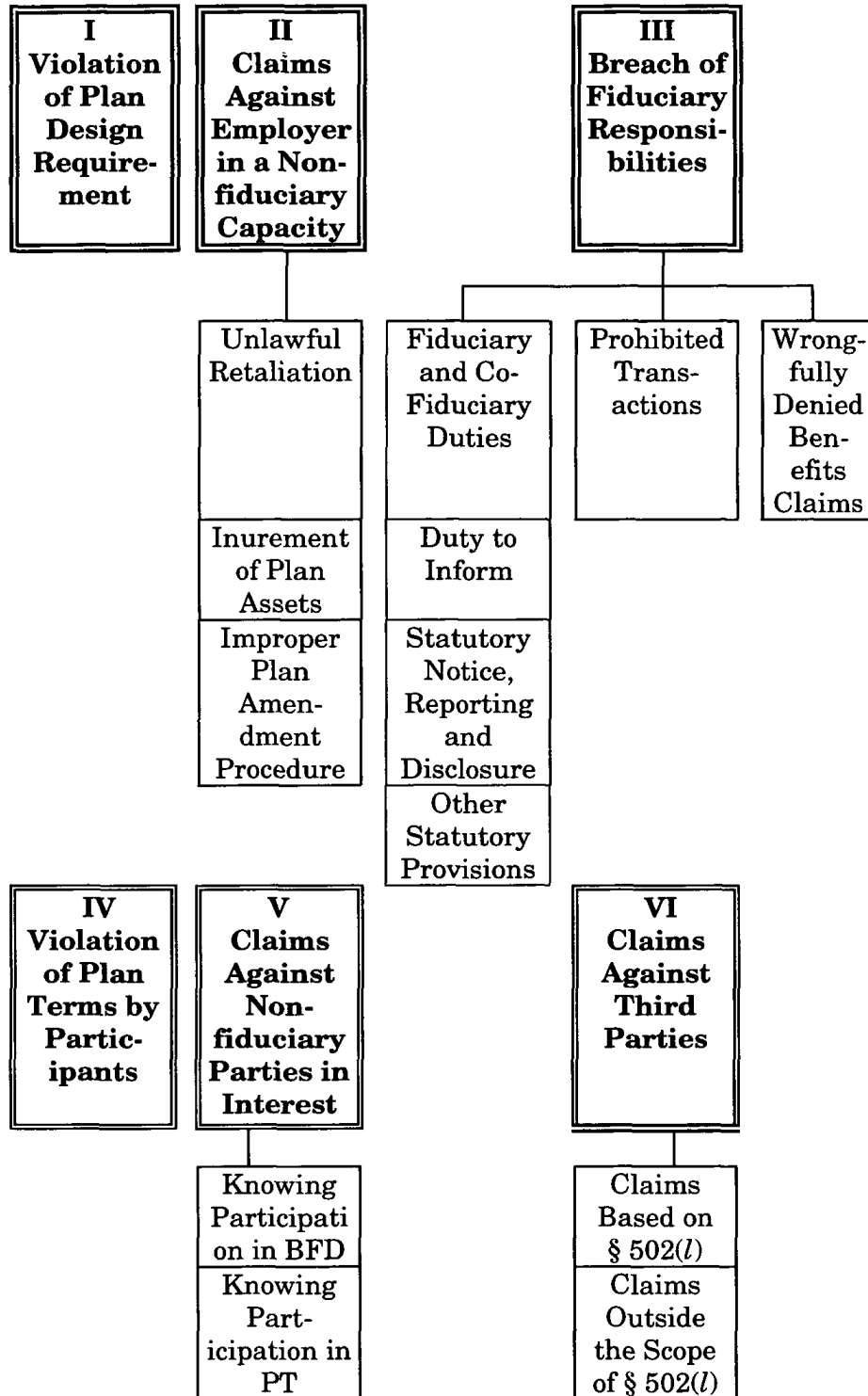
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430. See *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001). ("One of the principal goals of ERISA is to enable employers 'to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits.' Uniformity is impossible, however, if plans are subject to different legal obligations in different States." (citation omitted)).

431. 514 U.S. 645 (1995).

by showing the six categories of defendants and related claims, along with the particular subsets of claims possible within each category.

SUMMARY DIAGRAM OF CLAIMS CATEGORIES



#### D. Determining "Appropriate" Equitable Relief

Once the six categories of claims authorized by Section 502(a)(3) have been identified, it becomes possible to determine the types of equitable relief available for each category based on ERISA's underlying policies. Using this approach, the federal courts would no longer conceptualize the remedies available under Section 502(a)(3) as a potential judicial slippery slope. Rather, federal judges would be engaged in determining, in light of ERISA's policy objectives, the unique set of equitable remedies that are best-suited for each claim category. Different types of equitable remedies for each claim category may be "appropriate" because of the multiple, and sometimes conflicting, policies that underlie ERISA.

This proposed judicial approach is consistent with ERISA's legislative history. Congress intended the federal courts to interpret ERISA's new fiduciary responsibility standards "bearing in mind the special nature and purpose of employee benefit plans."<sup>432</sup> Congress further gave the federal courts the task of modifying the equitable remedies available under the common law of trusts where necessary to ensure effective enforcement of ERISA's policies.<sup>433</sup>

The devil in executing this task has always lain in the details. Exactly when are modifications to the equitable remedies available under the common law of trusts justified in light of the unique nature of the employee benefits system created by ERISA, and when are they not? Part III.D of the Article proposes a

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432. H.R. REP. NO. 93-1280, *reprinted in* 1974 U.S.C.C.A.N. at 5083; S. REP. NO. 93-127, *reprinted in* 1974 U.S.C.C.A.N. at 4865; H.R. REP. NO. 93-533, *reprinted in* 1974 U.S.C.C.A.N. at 4650; *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996).

433. *See Varity*, 516 U.S. at 497 (explaining that "ERISA's standards and procedural protections partly reflect a congressional determination that the common law of trusts did not offer completely satisfactory protection," and "courts must go on to ask whether, or to what extent, the language of the statute, its structure, or its purpose require departing from common-law trust requirements."); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989) ("[C]ourts are to develop a 'federal common law of rights and obligations under ERISA-regulated plans.'" (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987))); *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 155-57 (1985) (Brennan, J., concurring) (explaining that Congress authorized the federal courts to "fine-tune ERISA's remedial scheme" by developing federal common law to fashion appropriate equitable relief under Section 502(a)(3)); *Franchise Tax Bd. V. Construction Laborers Vacation Trust*, 463 U.S. 1, 24 n.26 (1983) ("[A] body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." (quoting 129 CONG. REC. 29942 (1974) (remarks of Sen. Javits))).

conceptual framework for the federal courts to use in resolving these questions.

1. *The ERISA Policy Triangle*

The three core policies that underlie ERISA form the foundation for my proposed conceptual framework, which I call the *ERISA Policy Triangle*. These three core ERISA policies are:

(1) to protect the rights of plan participants to the benefits promised to them under the terms of the plan (the “benefit protection policy”);

(2) to avoid imposing an undue administrative burden on employers that would financially deter them from voluntarily sponsoring plans for their employees (the “cost-minimization policy”); and

(3) to preserve the right of the employer as the settlor of the plan to customize the design of the plan and the plan’s package of benefits (within the limits of any statutory plan design requirements established by title I of ERISA) for the employer’s workforce and budget (the “settlor function policy”).

The benefit protection and cost-minimization policies are found in ERISA’s legislative history,<sup>434</sup> and the Supreme Court has expressly relied on those policies in several of its opinions interpreting Section 502(a)(3).<sup>435</sup> Less well-recognized, but equally important, is the settlor function policy, which derives from the judicially created settlor function doctrine.<sup>436</sup> The settlor function doctrine recognizes that an employer’s decision to establish, modify, amend, or terminate an employee benefit plan is not a fiduciary act,<sup>436</sup> and therefore it is not subject to judicial review for compliance with ERISA’s fiduciary duty provisions.<sup>437</sup> The policy

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434. H.R. REP. NO. 93-533, *reprinted in* 1974 U.S.C.C.A.N. at 4639-47; S. REP. NO. 93-127, *reprinted in* 1974 U.S.C.C.A.N. at 4838-51.

435. *See Varity*, 516 U.S. at 497 (stating that in interpreting the provision, courts must consider the competing goals of benefits protection and cost-minimization); *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262-63 (1993) (noting the tension between the two policies).

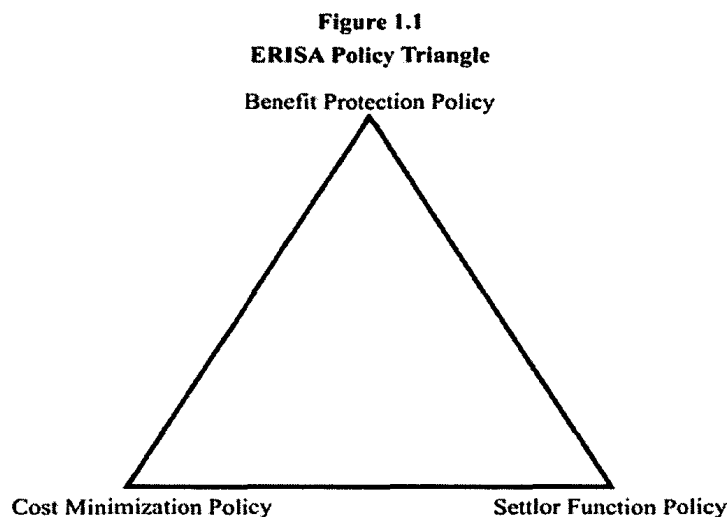
436. *See Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 443 (1999); *Lockheed Corp. v. Spink*, 517 U.S. at 882, 890 (1996) (explaining that plan sponsors who change the plan do not act as fiduciaries); *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) (“Employers...are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans”).

436. *Curtiss-Wright Corp.* 514 U.S. at 78.

437. *See Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 443 (1999);

purpose behind the settlor function doctrine is to encourage employers voluntarily to sponsor benefit plans by preserving the autonomy of the employer to make decisions concerning the benefits offered to employees based upon the nature of the employer's business, budget, and workforce.<sup>438</sup> Although the settlor function policy to date has not been expressly invoked by the Supreme Court in interpreting Section 502(a)(3), the policy has been invoked in the Supreme Court's analysis of breach of fiduciary duty claims<sup>440</sup> and claims of retaliation under Section 510 of ERISA.<sup>441</sup>

These three core ERISA policies and the interrelationships among them form the ERISA Policy Triangle, which is illustrated by Figure 1.1.



The ERISA Policy Triangle visually summarizes several fundamental principles. First, the primary benefit protection policy is superior to the secondary cost-minimization<sup>442</sup> and settlor function policies.<sup>443</sup> Hence, it has a superior location at the top of

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Lockheed Corp. v. Spink, 517 U.S. at 882, 890 (1996).

438. For further discussion on the settlor function doctrine see Colleen E. Medill, *supra* note 284 at 510 and Jane K. Stanley, *The Definition of Fiduciary Under ERISA: Basic Principles*, 27 REAL PROP. PROB. & TR. J. 237, 244-45 (1992).

440. *Hughes Aircraft Co.*, 525 U.S. at 443; *Lockheed Corp.*, 517 U.S. at 889-91.

441. See *Inter-Modal Rail Employees Ass'n. v. Atchison, Topeka & Santa Fe Ry. Co.*, 520 U.S. 510, 515-17 (1997).

442. *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262-63 (1993).

443. Under ERISA Section 404(a)(1)(D), the settlor's plan design is expressly made subject to the statutory requirements for employee benefit plans contained in title I of ERISA. 29 U.S.C. § 1104(a)(1)(D) (2000). These statutory requirements protect plan participants and their benefits. See

the triangle. Second, the cost-minimization and settlor function policies, which form the base of the triangle, are mutually reinforcing in the sense that an employer's choice of plan design often is related to minimizing the costs of plan sponsorship. Third, although the cost-minimization and settlor function policies are secondary, they form the supporting base for the employee benefits plan system. Plan sponsorship by employers is voluntary. Remedies jurisprudence under Section 502(a)(3) that "guts" this supporting base is likely to undermine the entire employee benefits system, and take with it the plan benefits that ERISA was enacted to protect.<sup>444</sup>

The ERISA Policy Triangle is a useful tool for conceptualizing how ERISA's overall statutory scheme balances these three core policies. Plan participants are closely associated with the apex of the ERISA Policy Triangle. Protection of this group represents ERISA's primary policy priority.<sup>445</sup> Protection of plan participants is achieved through ERISA's provisions for reporting and disclosure<sup>446</sup> and the statutory provisions that govern fiduciary conduct concerning the administration and management of the plan and its assets.<sup>447</sup> Additional statutory provisions for participants are provided through specific plan design requirements for retirement plans<sup>448</sup> and health care plans.<sup>449</sup>

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discussion *supra* Part III.B.1.

444. See *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 215 (2004) ("The limited remedies available under ERISA are an inherent part of the 'careful balancing' between insuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans." (citation omitted)).

445. See *Mertens*, 508 U.S. at 262-63 (referring to the goal of protecting employee benefits as primary); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) (stating that ERISA was enacted to protect participants). Some may argue that the protection of plan assets, rather than plan participants, is ERISA's primary policy priority. *Varity Corp. v. Howe*, 516 U.S. 489, 524-25 (1996) (Thomas, J., dissenting). The ultimate purpose of preserving plan assets, however, is to ensure that plan participants can receive their promised benefits. See H.R. REP. NO. 93-533, *reprinted in* 1974 U.S.C.C.A.N. at 4649-50; S. REP. NO. 93-127, *reprinted in* 1974 U.S.C.C.A.N. at 4865. As the majority in *Varity* made clear, the fiduciary duty provisions of ERISA are not simply limited to protection of plan assets, but rather also extend directly to the plan's participants. *Varity*, 516 U.S. at 507.

446. See 29 U.S.C. §§ 1021-1030 (2000) (establishing requirements for disclosure and reporting); see generally Peter J. Wiedenbeck, *Implementing ERISA: Of Policies and "Plans,"* 72 WASH. U. L.Q. 559, 567 (1994) (describing ERISA's notice and reporting requirements as disclosure controls).

447. See 29 U.S.C. §§ 1101-1110, 1133 (2000).

448. See 29 U.S.C. §§ 1052 establishing minimum participation standards for pension plans) (2000); § 1053 (establishing minimum vesting standards for pension plans) (2000); § 1054 (2000) (establishing benefit accrual requirements for pension plans and restrictions on pension plan amendments); § 1055 (2000) (establishing joint, survivor, and pre-retirement survivor annuity requirements for pension plans); § 1056 (2000) (establishing other requirements for the form and payment of benefits from pension plans); § 1058



Employers who sponsor plans, fiduciaries, and nonfiduciary parties-in-interest are closely associated with the left base of the ERISA Policy Triangle, which represents the cost-minimization policy. It is well recognized that this secondary policy may conflict with ERISA's primary policy of protecting plan participants. This inherent policy tension often requires the federal judiciary to engage in a balancing of competing policy objectives.<sup>450</sup>

Employers also are closely associated with the right base of the ERISA Policy Triangle, which represents the settlor function policy. The settlor function doctrine gives employers flexibility to design a system of plan benefits tailored to their particular businesses and budgets. The doctrine also allows employers to modify plan benefits to better accommodate changes in an employer's business or financial circumstances.<sup>451</sup> The employer's prerogative as settlor of the plan to amend the terms of the plan is secondary, however, to ERISA's statutory plan design requirements. Thus, where such statutory plan design requirements exist, the employer must amend the plan so as to continue to comply with any applicable statutory requirements.

## *2. Aligning Claim Categories and Policies*

Balancing these three core policies is a delicate, but not impossible, task for the federal courts in determining "appropriate" equitable remedies under Section 502(a)(3). The ERISA Policy Triangle provides an analytical framework to use in determining how each claim category aligns with each of ERISA's three core policies. Once this alignment is established, the remedies that are "appropriate" for each claim category can be more easily ascertained. Figure 1.2 below illustrates my proposed alignment position for each of the six categories of claims.

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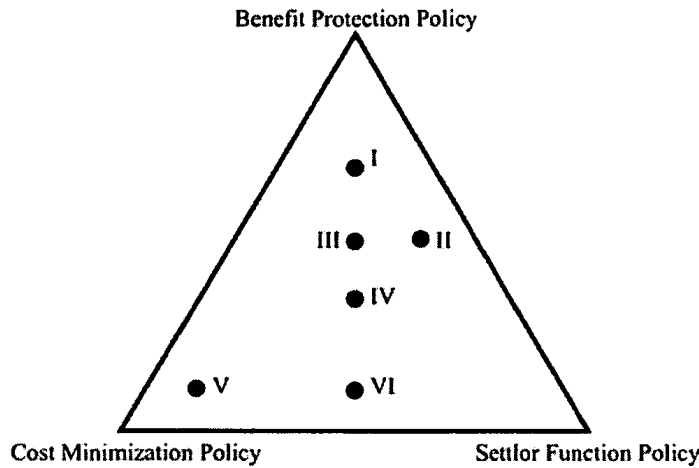
(2000) (establishing restrictions on the merger and consolidation of plans or the transfer of plan assets); § 1082 (2000) (establishing minimum funding standards for pension plans).

449. See 29 U.S.C. §§ 1161 (2000) (requiring group health plans to offer continuation of coverage under specified conditions); § 1169 (2000) (establishing other standards for group health plans); § 1181 (2000) (establishing limitations on pre-existing condition exclusions for health plans); § 1182 (2000) (prohibiting discrimination based on health status for health plans); § 1183 (2000) (regulating multi-employer health plans); § 1185 (2000) (establishing minimum benefit standards for mothers and newborns); § 1185a (2000) (establishing standards for mental health benefits); § 1185b (2000) (establishing standards for breast cancer-related benefits).

450. See *Varity*, 516 U.S. at 497 (stating that courts must consider the two competing policy goals); *Mertens v. Hewitt Assocs.*, 508 U.S. 243, 262-63 (1993) (noting the tension between the two policies).

451. *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 443 (1999); *Lockheed Corp. v. Spink*, 517 U.S. 882, 890 (1996).

**Figure 1.2**  
**Alignment of Policies and Claim Categories**



Category I claims involving a violation of ERISA's statutory plan design standards are very closely associated with the benefit protection policy. Category II claims for retaliation, improper plan amendment procedures, or inurement of plan assets, and Category III claims against a fiduciary for a violation of ERISA's fiduciary responsibility rules, function primarily to protect the rights of plan participants with respect to their plan benefits. Claims in Categories II and III are essential to deterring conduct by an employer, in both a nonfiduciary and fiduciary capacity, that would otherwise circumvent or erode ERISA's benefit protection policy. For these reasons, Categories I, II and III are assigned a position that is more closely aligned with the apex of the ERISA Policy Triangle. Because Category II claims also are strongly associated with the settlor function policy, Category II claims are placed toward the right side of the ERISA Policy Triangle.

Category IV claims against plan participants to enforce the terms of the plan implicate all three core ERISA policies. For this reason, Category IV claims are assigned a position in the center of the ERISA Policy Triangle that is equally related to all three policies. All of the plan's participants are subject to the terms of the plan. The plan terms dictate the benefits that each individual participant in the plan is entitled to receive. If an individual participant receives a greater benefit amount than is permitted under the terms of the plan, the administrator must have the ability to enforce the plan's terms and recoup the excess benefit amount. If the plan administrator is unable to effectively enforce the terms of the plan, ultimately the plan's ability to pay the benefits promised to the other participants financially may be compromised. ERISA's cost-minimization and settlor function policies also underlie Category IV claims. Lack of effective

enforcement of the plan's terms undermines the employer's ability to accurately estimate the costs of the plan's benefits and design a benefit structure that is affordable to the employer.

Category V claims against a nonfiduciary party in interest that are based on the Section 502(l) doctrine have as a prerequisite fiduciary misconduct.<sup>452</sup> Therefore, Category V claims that are based on Section 502 (l) are properly conceptualized as secondary to, and thus aligned below, a Category III claim for breach of fiduciary responsibility.

Parties in interest often have a statutorily recognized connection with the operation and administration of the plan. Such defendants are likely to react negatively to judicial remedies under Section 502(a)(3) that effectively increase their risk of potential liability. To the extent that the relationship of a Category V defendant to the plan is based on nonfiduciary services involving plan administration or transactions involving plan assets, such Category V defendants are likely to respond to increased risk by raising the price of their services. For this reason, Category V claims generally are more closely associated with the cost-minimization policy that forms the left base of the ERISA Policy Triangle.

A Category VI claim is brought against an unrelated third party who is not subject to ERISA's regulatory scheme. Fundamentally, Category VI defendants are persons whom Congress did not view as integral to the protection of plan benefits and the associated rights of plan participants. Such unrelated third party defendants have no direct connection with the plan itself. Rather, these defendants may have an indirect connection with the plan through a relationship with another person whose conduct is regulated by either the statutory provisions of title I of ERISA or by the terms of the plan itself.

A Category VI claim that satisfies the statutory elements of Section 502(l) is, like a similar Category V claim, secondary to a prerequisite Category III claim against a fiduciary. A Category VI claim against a third party may, however, be outside the scope of Section 502(l) and yet still present a viable claim under Section 502(a)(3). Although this type of Category VI claim is difficult to align with policy objectives in the abstract, one likely scenario is that the claim is outside the scope of Section 502(l) because the third party has knowingly participated in a violation of plan terms by a plan participant. Therefore, the element of fiduciary misconduct is missing. With the substantial caveat that Category VI claims are the claim category least susceptible to generalization, I aligned Category VI claims along the baseline of the ERISA Policy Triangle underneath both Category III claims

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452. See discussion *supra* Part III.C.3.e.

against fiduciaries and Category IV claims against plan participants.

3. *Aligning Claim Categories with “Appropriate” Equitable Remedies: Some Observations Concerning Emerging Issues and Proposed Judicial Solutions*

The Supreme Court has made clear that the remedies of injunction, mandamus, and restitution are available for each of the six categories of claims that may be brought under Section 502(a)(3).<sup>453</sup> In the future the Supreme Court will have the opportunity to add to and further clarify this list. In particular, the law of restitution includes a variety of equitable devices such as the equitable lien<sup>454</sup> and its close cousin, the constructive trust.<sup>455</sup> Other possible remedies are derived from the common law of trusts, such as money damages awarded under a make-whole relief standard,<sup>456</sup> and judicial reformation of trust terms.<sup>457</sup> Finally, the Supreme Court may reconsider the availability of a monetary award under Section 502(a)(3) in exceptional cases where a wrongful denial of a claim for plan benefits injures the plan participant.<sup>458</sup> In this part of the Article, I offer some observations concerning remedies available under Section 502(a)(3) and suggest the categories of claims for which various equitable remedies are well-suited based on ERISA’s underlying core policies. I also explain why, based on ERISA’s statutory provisions, not all remedies available in equity under the common law of trusts should be imported into Section 502(a)(3).

a. *Monetary Awards: Restitution Versus Make-Whole Relief*

For purposes of discussion, it is important to explain what I mean by the terms “restitution” and “make-whole relief.” I use the term “restitution” to refer to a monetary award in an amount that is necessary to prevent the unjust enrichment of the defendant. Thus, if the defendant has not been enriched by his wrongful conduct, restitution is not available as a remedy.

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453. See *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 215 (2002); *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256-58 (1993).

454. See *Sereboff v. Mid Atlantic Medical Servs., Inc.*, 126 S. Ct. 1869 (2006); RESTATEMENT OF RESTITUTION § 161 (1937) (providing that when a person can reach another’s property in equity as security for a claim based on unjust enrichment, an equitable lien is formed).

455. See *Great-West*, 534 U.S. at 213; RESTATEMENT OF RESTITUTION § 160 (1937).

456. See Langbein, *supra* note 13, at 1333-38.

457. See RESTATEMENT (THIRD) OF TRUSTS §62 cmt. b (2003) (explaining that judicial reformation of trust terms is permitted if a mistake of fact or law affects the specific terms of the document).

458. See *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 222-23 (2004) (Ginsburg, J., concurring).

I use the term “make-whole relief” to refer to a monetary award in an amount that will “restore[] the victim to the position that he or she would have had”<sup>459</sup> but for the defendant’s wrongful conduct. Because make-whole relief focuses on the plaintiff’s injury, it may be awarded even if the defendant has not been unjustly enriched as a result of the ERISA violation or the terms of the plan. For the moment, I am purposefully limiting the term “make-whole relief” in this discussion to a monetary award calculated to restore the plaintiff’s *economic* losses. Later in Part III.D.3.d of the Article, I take up the question of whether Section 502(a)(3) could be read to authorize a monetary award designed to compensate the plaintiff for *physical and emotional pain and suffering* caused by a wrongful denial of plan benefits under Section 502(a)(1)(B).

When the plaintiff seeks a monetary award, the policy distinctions between Category I, II, and III claims, and Category IV, V, and VI claims, justify corresponding distinctions among the available remedies. Monetary awards for Category I, II, and III claims should be determined under the more comprehensive make-whole relief standard. For these categories of claims, the defendant’s lack of unjust enrichment should not prevent the federal courts from providing a remedy under Section 502(a)(3) for the plaintiff’s economic losses. Permitting monetary awards under a make-whole relief standard for Category I, II, and III claims also serves to encourage employers and plan fiduciaries to comply with ERISA’s regulatory regime by providing a significant financial deterrent for violations. This policy justification is especially strong in the context of Section 510 claims for retaliation. As applied in the context of a Category II claim under Section 510, make-whole relief necessarily would include back-pay, and in some situations may also necessitate front-pay, as appropriate forms of make-whole relief.

Proposing that monetary awards based on a make-whole relief standard should be available for Category I, II, and III claims does not mandate that the federal courts must, in every instance, award monetary make-whole relief for such claims in every case. Section 502(a)(3)’s statutory authorization of “equitable relief” is modified by the word “appropriate.”<sup>460</sup> There may be instances where ERISA’s secondary policy objectives render a sizeable monetary award based on a make-whole relief standard “inappropriate.” For example, if the proper interpretation of a statutory requirement for plan benefits design is subject to substantial uncertainty,<sup>461</sup> the federal court may

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459. Langbein, *supra* note 13, at 1335 & n.102.

460. See 29 U.S.C. § 1132(a)(3)(ii)(B) (2000).

461. Here, the example that comes to mind is the application of ERISA’s statutory provision prohibiting age discrimination to cash balance plans. See

consider the potential chilling effect a large monetary award based on a make-whole relief standard may have on other employers who voluntarily sponsor similar plans.<sup>462</sup> Where the potential chilling effect may harm the overall employee benefits system, the federal court may choose to render a monetary award that is limited to the extent of the employer's unjust enrichment (if any), or award another form of equitable relief, such as injunctive relief.

ERISA's cost-minimization policy justifies a restitution standard for monetary awards for Category V claims against a nonfiduciary party in interest who knowingly participates in a breach of fiduciary duty or a prohibited transaction. Financial liability under ERISA is a factor that influences the price that plan service providers — the primary pool of potential defendants for Category V claims — charge for the services they provide to the employer who voluntarily sponsors the plan.<sup>463</sup> Limiting monetary awards for Category V claims to the amount of the defendant's unjust enrichment avoids the chilling effect that application of a make-whole relief standard would have on plan service providers. For Category V claims, the more limited standard of restitution as necessary to prevent the unjust enrichment of the party in interest defendant strikes the correct balance between the benefit-protection policy and the cost-minimization policy.

Restitution is also a more suitable standard than make-whole relief for monetary awards for Category VI claims. Category VI claims involve a third party defendant whose conduct is not directly regulated under ERISA's statutory scheme. ERISA's failure to regulate directly third party defendants warrants caution in awarding any form of monetary relief for a Category VI claim. It would be a foolish overabundance of caution, however, for the federal courts effectively to create a license for these third party defendants to profit or benefit at the expense of the plan and its participants by knowingly assisting a fiduciary or a plan participant who violates the terms of title I of ERISA or the terms

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29 U.S.C. § 1054(b)(1)(H)(i) (2000).

462. The uniqueness of the terms of the plan that are challenged as illegal would be an additional factor for the federal court to consider in determining whether a monetary award based on a make-whole relief standard is "appropriate" under Section 502(a)(3). Obviously, the more unique the challenged provisions of the plan, the less likely a monetary award based on a make-whole relief standard would deter other employers from voluntarily sponsoring plans for their employees.

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All that ERISA has eliminated... is the common law's joint and several liability, for *all* direct and consequential damages suffered by the plan, on the part of persons who had no real power to control what the plan did. Exposure to that sort of liability would impose high insurance costs upon persons who regularly deal with and offer advice to ERISA plans, and hence upon ERISA plans themselves.

Mertens v. Hewitt Assocs., 508 U.S. 248, 262 (1993).

of the plan. Under these circumstances, the federal courts should deter such conduct by third party defendants by permitting a monetary award based on a restitution standard against the third party defendant.

Category IV claims against plan participants present a more complex range of situations and circumstances. For example, in mistaken overpayment cases where the plan administrator errs and overpays benefits due the participant—wholly innocent of wrongdoing—under the terms of the plan, under principles of equity a monetary award measured by a restitution standard seems more “appropriate” than a make-whole relief standard. A restitution standard would return the participant’s windfall back to the plan. If the plan administrator’s mistake caused economic injury to the plan that is not fully compensated by the participant’s restitution (such as where the plan has suffered lost investment earnings) it is the plan administrator who should make up the shortfall to cure the administrator’s breach of fiduciary duty in originally authorizing the overpayment. Conversely, if the overpayment is the product of fraud or misrepresentation by the participant, or the participant has knowingly violated the terms of the plan, a make-whole relief standard for a monetary award against the participant would discourage such conduct in the future by other plan participants.

b. Reformation and “Quasi-Reformation” (Equitable Estoppel as a Remedy)

If the federal courts recognize a make-whole relief standard for monetary awards, the question is likely to arise whether other equitable remedies that are unique to the world of the common law express trust are available under Section 502(a)(3). One such unique trust law remedy is judicial reformation of the terms of the trust agreement that are affected by a mistake of law or fact.<sup>464</sup> The nature and circumstances of a Category I claim based on illegal plan terms may suggest reformation as a possible form of equitable relief under Section 502(a)(3). A close cousin to reformation (so close, in fact, I refer to it as “quasi-reformation”) is the remedy of equitable estoppel for Category III claims involving a breach of the fiduciary’s duty to inform<sup>465</sup> or a fiduciary’s failure to comply with ERISA’s notice and disclosure requirements by providing a participant with a flawed summary plan description.<sup>466</sup>

Where the claim under Section 502(a)(3) is that the terms of the plan violate one of ERISA’s statutory plan design requirements, the federal courts have at least two other equitable

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464. RESTATEMENT (THIRD) OF TRUSTS §62 cmt. b (2003).

465. See discussion *supra* Part III.C.3.c.ii.

466. See discussion *supra* Part III.C.3.c.iii.

remedies available in addition to reformation. If the illegal terms are the product of a plan amendment, the federal court may exercise its equitable powers of injunction and mandamus to declare the amendment to be void and unenforceable, thereby returning the plan's benefit design to the pre-amendment status quo.<sup>467</sup> Or, the federal court may exercise its equitable injunctive powers and order the employer to enact retroactively an amendment to the plan that conforms the terms of the plan to ERISA's statutory plan design requirements.<sup>468</sup>

There are both practical and policy-based reasons why the federal courts should not embrace judicial reformation as a third alternative to these two remedies for a Category I claim under Section 502(a)(3). From a practical perspective, any amendment to the terms of a qualified retirement plan<sup>469</sup> would require the drafter to have specialized legal expertise in the highly technical rules of the Internal Revenue Code.<sup>470</sup> In the defined benefit plan context, specialized actuarial expertise often is needed to resolve claimed violations of ERISA's vesting and benefit accrual plan design standards.<sup>471</sup> To state the obvious, few federal judges are competent to undertake this complex drafting task. Those who are competent are likely to prove wise enough to be unwilling.

From a policy perspective, for qualified retirement plans there are often multiple compliance options available to the employer under ERISA's statutory plan design standards.<sup>472</sup> Judicial

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467. See Frank P. VanderPloeg, *Role-Playing Under ERISA: The Company as "Employer" and "Fiduciary"*, 9 DEPAUL BUS. L.J. 259, 276 (1997) (arguing that an amendment that violates the plan design requirements of ERISA should be viewed as illegal and therefore void). Nullifying a purported plan amendment was the remedy approach adopted by the Third Circuit in *Curtiss-Wright Corp. v. Schoonejongen*, 18 F.3d 1034, 1036 (3d Cir. 1994). The Third Circuit adopted this remedy after finding that the plan's document failed to specify an amendment procedure as required by Section 402(b)(3), 29 U.S.C. § 1102(b)(3) (2000), thereby rendering the attempted plan amendment void. *Curtiss-Wright Corp.*, 18 F.3d at 1040. The Supreme Court reversed the Third Circuit because the Court found that the plan's amendment procedure satisfied ERISA's statutory requirement. See *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78-85 (1995). The Supreme Court expressly did not reach the question of whether the Third Circuit's remedy, declaring the amendment to be invalid, was permissible. *Id.* at 85.

468. See *Devito v. Pension Plan of Local 819 I.B.T. Pension Fund*, 975 F. Supp. 258, 266-70 (S.D.N.Y. 1997) (holding that the court need not decide whether it has jurisdiction to reform the plan benefit formula that violates ERISA because court may order plan sponsor to adopt retroactive amendment to benefit formula that conforms the formula to ERISA's requirements).

469. The term "qualified retirement plan" refers to a pension plan that is intended to comply with the statutory requirements described in Section 401(a) of the Internal Revenue Code, I.R.C. § 401(a)(2006).

470. See I.R.C. § 401(a).

471. See 29 U.S.C. §§ 1053-54 (2000).

472. See *Devito*, 975 F. Supp. at 267-70.



reformation of the plan would usurp the employer's right under the settlor function policy to select the compliance option that is best suited to the employer's unique business operations, workforce and financial circumstances. Judicial reformation also would undermine the cost-minimization policy. It is the employer sponsoring the plan who would bear the unanticipated cost of any additional benefits provided by a judicially reformed plan. The very possibility of judicial reformation might have a chilling effect on employers, who may exercise their prerogative to terminate the plan altogether.

It is entirely possible to conceive of a Category I claim where the alleged statutory violation does not involve a qualified retirement plan or present alternative methods of compliance. For example, the requirements for health plan continuation coverage<sup>473</sup> or the requirements for health care plan eligibility and benefits<sup>474</sup> may present a clear violation, sympathetic facts, and a defiant and recalcitrant employer. Under these circumstances, a federal judge may be tempted to award instantaneous relief from the bench in the form of judicial reformation of the illegal plan terms. Even under such egregious circumstances, the better interpretation of "equitable relief" available under Section 502(a)(3) is that judicial reformation of illegal plan terms is not available as a remedy. Quite simply, judicial reformation of plan terms is not "appropriate" because such reformation is contrary to the spirit, if not the letter, of both the written plan document rule of Section 402(a)(1)<sup>475</sup> and the plan amendment procedure rule of Section 402(b)(3).<sup>476</sup>

Fortunately, remedies other than reformation are available to protect plan participants in these circumstances. The federal court may enjoin the implementation of an illegal plan amendment, and thereby reinstate the original plan terms. Or, the federal court may issue an order pursuant to the court's injunctive and mandamus powers that requires the employer to amend the plan retroactively to comply with ERISA's statutory design requirements.<sup>477</sup> These equitable remedies, when combined with monetary make-whole relief if necessary, are adequate to protect plan participants and restore any benefits due to them under the statutory plan design requirements of title I of ERISA.

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473. 29 U.S.C. §§ 1161-69 (2000).

474. 29 U.S.C. §§ 1171-85(b) (2000).

475. 29 U.S.C. § 1102(a)(1) (2000).

476. 29 U.S.C. § 1102(b)(3)(2000).

477. See *Devito v. Pension Plan of Local 819 I.B.T. Pension Fund*, 975 F. Supp. 258, 270 (S.D.N.Y., 1997) (ordering plan sponsor to adopt retroactive amendment to bring benefit formula into compliance with ERISA requirements).

Similar policy considerations render “quasi-reformation,” pleaded by the plaintiff in the form of an equitable estoppel remedy, an inappropriate form of equitable relief under Section 502(a)(3). Equitable estoppel may be asserted as an equitable remedy (rather than as a type of federal common law *claim*<sup>478</sup>) for Category III claims involving a breach of the fiduciary’s duty to inform or based on a fiduciary’s failure to comply with ERISA’s statutory notice and disclosure requirements. If the federal courts embrace a make-whole relief standard for monetary awards under Section 502(a)(3) as a remedy for Category III claims, the need for equitable estoppel as a remedy vanishes. The better judicial interpretation is for the federal courts to reject equitable estoppel as a remedy under Section 502(a)(3), and instead award monetary relief based on a make-whole relief standard for Category III claims.

c. The Equitable Lien and the Constructive Trust

Earlier in the Article, I described the Supreme Court’s decision in *Sereboff v. Mid Atlantic Medical Services, Inc.*,<sup>479</sup> where the Court explicitly recognized the equitable devices of the equitable lien and the constructive trust as forms of restitution available as remedies under Section 502(a)(3). I also predicted how, in the future, participants and their tort attorneys may attempt to avoid reimbursement to the plan by circumventing the facts of *Sereboff*.<sup>480</sup>

In applying the equitable lien and the constructive trust as remedial equitable devices available as restitutionary relief under Section 502(a)(3), federal courts should follow the congressional directive to “bear[ ] in mind the special nature and purpose of employee benefit plans.”<sup>481</sup> In future cases, the federal courts should be flexible in construing the technical elements required at common law for the imposition of an equitable lien or a constructive trust.<sup>482</sup> For example, a strict judicial interpretation of the common law requirement of a “separate fund” to which an equitable lien can attach would only encourage participants or their tort attorneys to commingle or dissipate the tort recovery funds. The federal courts should interpret the federal law standards for the imposition of an equitable lien or a constructive

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478. See discussion *infra* Appendix A.

479. 126 S. Ct. 1869 (2006).

480. See discussion *supra* Part III.C.3.f.ii.

481. H.R. REP. NO. 93-1280 reprinted in 1974 U.S.C.C.A.N. at 5083; S. REP. NO. 93-127, reprinted in 1974 U.S.C.C.A.N. at 4865; H.R. REP. NO. 93-533, reprinted in 1974 U.S.C.C.A.N. at 4650; *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996).

482. See *Sereboff*, 126 S. Ct. at 1875 (rejecting application of “strict” tracing rules required for imposition of an equitable lien at common law).

trust under Section 502(a)(3) in a manner that will encourage compliance with the terms of the plan, rather than rewarding defendants who violate these terms.

d. Monetary Awards for a Wrongful Denial of Plan Benefits

The “rule” that monetary awards are not available as additional equitable relief under Section 502(a)(3) for economic losses or personal injury caused by a wrongful denial of plan benefits under Section 502(a)(1)(B) dates back to the Supreme Court’s decisions in *Massachusetts Mutual Life Insurance Co. v. Russell*.<sup>483</sup> In *Russell*, the Supreme Court characterized the plaintiff’s claim for monetary compensation for economic losses and physical and mental pain and suffering resulting from an improper delay in processing the participant’s claim for disability plan benefits as “extra-contractual.” The term “extra-contractual” was the *Russell* Court’s short-hand reference for a monetary award that goes beyond the benefits the participant is entitled to receive under the contractual terms of the plan. *Russell* held that “extra-contractual” monetary awards are not available as a remedy under Section 502(a)(2) of ERISA, which was the sole statutory basis for relief asserted by the *Russell* plaintiff, because in the context of *Russell* a monetary award was not “plan-wide” relief.<sup>484</sup>

All nine Justices in *Russell* agreed with this interpretation of the remedy available under Section 502(a)(2).<sup>485</sup> The Justices were sharply divided (5-4) over whether such a monetary award to the participant might be available under Section 502(a)(3) of ERISA.<sup>486</sup>

Eight years after *Russell*, the Supreme Court addressed the types of “equitable” relief available under Section 502(a)(3) in *Mertens v. Hewitt Associates*.<sup>487</sup> The precise question before the Supreme Court in *Mertens* was whether a remedy of money damages was available under Section 502(a)(3). The majority, in a 5-4 decision, ruled that the damages remedy requested by the participants was not available under Section 502(a)(3) because “[m]oney damages are, of course, the classic form of *legal* relief.”<sup>488</sup>

Writing for the majority in *Mertens*, Justice Scalia found that Congress purposefully used the word “equitable” to limit the remedies available under Section 502(a)(3) to exclude monetary

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483. 473 U.S. 134 (1985).

484. *Id.* at 139-42.

485. *Id.* The plaintiff in *Russell* expressly disclaimed reliance on Section 502(a)(3) in asserting her claim. *Id.* at 139, n.5.

486. *See id.* at 150-54 (Brennan, J., concurring).

487. 508 U.S. 248, 257 (1993). The need to define “equitable” relief did not arise in *Russell* because Section 502(a)(2) authorizes both legal and equitable relief. 29 U.S.C. §§ 1132(a)(2), 1109(a) (2000).

488. 508 U.S. at 255 (emphasis in original).

damages, which were classified as “legal” relief.<sup>489</sup> Justice White, the author of the dissenting opinion in *Mertens*, offered an alternative explanation of the statutory text. He proposed that Congress have used the term “equitable” to exclude *punitive* damages from Section 502(a)(3), while still permitting monetary awards as a formal equitable “make-whole” relief.<sup>490</sup>

Justice White’s proposed interpretation of the statutory language has subsequently been corroborated by the insider eyewitness account of the late Michael Gordon, who was appointed to serve as minority counsel to the Senate Committee on Labor and Public Welfare from 1970 to 1975. In a letter to the authors of the *ERISA Litigation Reporter*, Mr. Gordon stated:

In *Mertens*, Scalia derides the notion that Congress wrote Section 502(a) the way it did because it was concerned about punitive damages. He is wrong. In *Russell*, Stevens notes that the Senate version of ERISA referred to both legal and equitable remedies but the last version passed by the House and accepted in the ERISA Conference deleted the reference to legal remedies, the implication being—since ERISA is a “comprehensive and reticulated” statute—that punitive damages were being excluded. He is also wrong; the matter was being fudged. Why was the matter being fudged? . . .

Certain key legislators in both the Senate and House felt that if ERISA automatically provided access to punitive damages relief, it would send a signal that Congress thought the Age Discrimination in Employment Act of 1967 should provide the same relief and that Congress would overturn any court decision that ruled otherwise. Of course, that possibility would create another cross for ERISA to bear as opponents of ERISA were, as we know, looking for any opportunity at hand to stop the bill’s enactment. This meant that the references in Section 502(a) to “legal” relief had to be deleted.

However, from the viewpoint of Senator Javits (and yours truly), the deletion of “legal” relief did not mean there would never be access to punitive damages under ERISA. In New York, then regarded as the most important jurisdiction in terms of state jurisprudential leadership, the merger of law and equity had proceeded quite rapidly and the highest New York appellate court had ruled that punitive damages could be awarded by a court of equity in appropriate cases. The New York position could be harmonized with the political imperative of avoiding embroiling the ERISA conferees in yet another potentially ruinous dispute . . . . [To t]hose who understood the trend toward the law-equity merger, it meant that they would not be totally abandoning their desire to preserve access to punitive damages relief; it only meant that access to such relief would be provided infrequently and only under the most compelling circumstances. There was nothing wrong with that. Even with

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489. *Id.* at 255-58.

490. *See id.* at 270-73 (White, J. dissenting).

Scalia's views on legislative history and the role of staff, none of the foregoing has any official standing or legal significance. But it does unofficially reinforce the suspicion that Scalia is off the mark in holding fast to the myth that the ERISA authors only intended to enact "typical" equitable remedies and that they rejected the law-equity merger process, then at its peak.<sup>491</sup>

Following *Mertens*, in *Variety Corp. v. Howe*<sup>492</sup> the Supreme Court acknowledged that a wrongful denial of plan benefits under Section 502(a)(1)(B) also was a breach of fiduciary duty that could give rise to a claim for additional equitable relief under Section 502(a)(3).<sup>493</sup> The *Variety* Court concluded that "normally" further relief under Section 502(a)(3) would not be appropriate, given that Congress explicitly had authorized a remedy under Section 502(a)(1)(B).<sup>494</sup> But the Supreme Court's statements in *Russell* and *Variety* do not *preclude* awarding additional monetary relief under Section 502(a)(3) in extraordinary cases of harm or hardship to the participant resulting from a plan administrators' wrongful denial of plan benefits.

The real obstacle to such a monetary award under Section 502(a)(3) is, I suspect, the perceived risk of a judicial slippery slope. It is certainly possible that using Section 502(a)(3) to make the participant whole might result in a legal effect judicial slippery slope,<sup>495</sup> where awarding additional monetary relief based on a make-whole standard becomes the "normal" rule any time a plaintiff successfully brings a claim for wrongfully denied benefits under Section 502(a)(1)(B).

In addressing the potential risk of a judicial slippery slope, Professor Eugene Volokh's theory of slippery slope counter mechanisms is again instructive.<sup>496</sup> Fundamentally, it is the statutory basis for the plaintiff's primary claim that forms a sound basis for drawing a distinction. Make-whole relief is an appropriate equitable remedy under Section 502(a)(3) when the plaintiff's primary claim is based on a violation of a fiduciary responsibility provision of ERISA.<sup>497</sup> In contrast, the statutory basis of the participant's primary claim for wrongfully denied benefits is Section 502(a)(1)(B).<sup>498</sup> It is only after the plaintiff's claim under Section 502(a)(1)(B) has been *proven successfully by the plaintiff* that the possibility of additional relief, in the form of a

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491. *Supreme Court Announces That It Was Not Kidding*, *supra* note 96, at 6-8 (citations omitted).

492. 516 U.S. 489, 514-15 (1996).

493. See discussion *supra* Part III.C.2.a.

494. 516 U.S. at 515.

495. See discussion *supra* Part II.C.2.

496. See discussion *supra* Part II.C.2.

497. See Langbein, *supra* note 13, at 1319-20.

498. 29 U.S.C. § 1132(a)(1)(B).

monetary award based on a make-whole standard, would arise under Section 502(a)(3).

Monetary make-whole relief normally would be awarded in any case where the plaintiff's primary claim is for a breach of fiduciary responsibility by the defendant. In contrast, where the plaintiff's primary claim is a wrongful denial of plan benefits, the normal remedy under *Varity* would be the remedy offered by Section 502(a)(1)(B), which is limited to the payment of benefits that should have been paid based on the terms of the plan. Only in "extraordinary" cases would additional monetary relief be awarded under Section 502(a)(3) to a plaintiff who was injured personally by a denied claim for plan benefits.

This claim-based distinction negates the risk of a legal effect judicial slippery slope. Yet there remains the problem of potential equality/administrative cost judicial slippery slope.<sup>499</sup> This type of slippery slope risk arises if federal judges are unable to distinguish "normal" denial of benefits cases (where the "normal" remedy would be limited to the payment of benefits due under Section 502(a)(1)(B)) from "extraordinary" denial of benefits cases (where additional monetary relief could be awarded under Section 502(a)(3)). I propose that this risk can be reduced to a tolerable level through definitive guidance to the lower federal courts in future Supreme Court opinions.

Such definitive guidance should begin with the statutory language of Section 502(a)(3). To award an additional monetary award under Section 502(a)(3), an additional remedy beyond the limited remedy provided by Section 502(a)(1)(B) must be "appropriate." To determine whether an additional award is "appropriate" under Section 502(a)(3), the federal courts first should consider whether a state law claim, such as a medical malpractice claim, is available to the participant. The federal courts should consider further whether, if successful, a state law claim could result in a damages award that may compensate the participant for all or part of the participant's injuries. Clearly, if the participant also has a viable claim under state law, an award of additional monetary relief under Section 502(a)(3) could be duplicative, and therefore would not be considered "appropriate."

In cases where a state law claim and remedy are not available to the participant, the plaintiff-participant should bear the burden of proving that additional monetary relief under Section 502(a)(3) is "appropriate." To determine whether the participant has satisfied this burden of proof, the federal courts should weigh and balance the potential for discouraging and deterring employers from voluntarily sponsoring benefit plans (the cost-minimization

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499. See discussion *supra* Part II.C.2.

and settler-function policies) against the following factors (which serve as indicia of the benefit protection policy):

- (1) the gravity of the economic loss and personal injury caused by the plan administrator's wrongful denial of plan benefits to the participant;
- (2) whether the participant's injuries were foreseeable;
- (3) the degree of abuse of fiduciary discretion by the plan administrator in denying the participant's claim for benefits;
- (4) whether the plan administrator's exercise of fiduciary discretion was tainted by a pecuniary conflict of interest, or in the more egregious cases, whether there was a pattern and practice of systematically denying claims;<sup>500</sup> and
- (5) the potential future deterrent effect of an additional monetary award.

The fifth factor, the potential deterrent effect of an additional award, reflects a balancing of ERISA's competing policy goals. An additional monetary award in cases involving a high degree of fiduciary abuse in interpreting the terms of the plan would promote ERISA's benefit-protection policy by deterring such conduct in the future. The policy argument against an additional monetary award under Section 502(a)(3) centers around ERISA's cost-minimization policy. In considering this fifth factor, there are several considerations that may render a cost-minimization policy argument less compelling.

First, *Varity* instructs that normally the remedy under Section 502(a)(1)(B) will "normally" be adequate.<sup>501</sup> Second, the pool of cases that potentially will qualify for consideration of an additional monetary award under Section 502(a)(3) will be limited to situations where an adequate remedy is not available under state law, and where severe bodily injury or serious economic harm to the participant that was foreseeable has resulted from the wrongfully denied claim for plan benefits. Third, the risk of an additional monetary award that is disproportionate to the degree of abuse of fiduciary discretion by the plan administrator in denying the participant's claim for benefits and the severity of the participant's resulting injuries is low. If additional monetary

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500. For example, a pattern and practice by the insurer of systematically denying claims has been found in the context of claims for long-term disability plan benefits. See *Radford Trust v. First UNUM Life Ins. Co. of Am.*, 321 F. Supp. 2d 226, 247-49 (D. Mass. 2004).

501. See discussion *supra* Part III.C.2.a.

relief under Section 502(a)(3) is characterized as “equitable,” then a jury trial is not available.<sup>502</sup> Rather, the amount of an additional monetary award will be determined by a federal district court judge at the conclusion of a bench trial for the participant’s claims. Moreover, the district court’s monetary award will be subject to

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502. The Seventh Amendment provides that “[i]n suits at common law . . . the right of trial by jury shall be preserved.” U.S. Const. amend. VII. The Seventh Amendment right to a jury trial extends to “actions enforcing [federal] statutory rights, and requires a jury trial upon demand, if the state creates legal rights and remedies, enforceable in an action for damages in the ordinary courts of law.” *Curtis v. Loether*, 415 U.S. 189, 194 (1974). To determine whether a claim under a federal statute involves legal rights and remedies, the Supreme Court engages in a two-step analysis. The first step is to compare “the statutory action to 18th-century actions brought in the courts of England prior to the merger of the courts of law and equity.” *Teamsters Local No. 391 v. Terry*, 494 U.S. 567, 565 (1990). The second step is to “examine the remedy sought and determine whether it is legal or equitable in nature.” *Id.* Of these two steps, the Supreme Court weighs the second one more heavily in its analysis. *Id.*

The Supreme Court has never addressed expressly the right to a jury trial for claims under ERISA. In *Great-West*, the Supreme Court stated that “restitution is a legal remedy when ordered in a case at law and an equitable remedy . . . when ordered in an equity case, and whether it is legal or equitable depends on the basis for the plaintiffs claim and the nature of the underlying remedies sought.” *Great-West Annuity & Life Ins. Co. v. Knudson*, 534 U.S. 204, 213 (2002) (quoting *Reich v. Continental Casualty Co.*, 33 F.3d 754, 756 (7th Cir. 1994)). This statement suggests that claims under Section 502(a)(3) seeking monetary relief, either as restitution or as make-whole relief based on the common law of trusts, would not be subject to a jury trial.

Further support for the conclusion that a jury trial right is not available for claims brought under Section 502(a)(3) is found in the historical evolution of the common law courts of chancery. At early common law, enforcement of the terms of a trust agreement by a chancery court of equity, rather than by a court of law, evolved in part as a response to the procedural weaknesses inherent in cases tried before a jury. See John H. Langbein, *The Contractarian Basis of the Law of Trusts*, 105 YALE L. J. 625, 635 (1995). For example, at early common law the parties to civil litigation were disqualified from testifying before the jury due to their self-interest in the outcome of the litigation. *Id.* at 635. As Professor Langbein notes, in the case of a dispute over interpretation or enforcement of the terms of a trust, such “a rule would have silenced most of the relevant persons in a trust case.” *Id.* In contrast, a court of equity could hear such testimony in cases involving the enforcement of the terms of the trust. *Id.* at 635-36.

Claims concerning trust administration historically were resolved by a chancery court judge, not by a jury. “Questions of the administration of trusts have always been regarded as of a kind which can adequately be dealt with in a suit at equity rather than in an action at law, where questions of fact would be determined by a jury and not by the court.” RESTATEMENT (SECOND) OF TRUSTS § 197 cmt. b (1959); RESTATEMENT OF TRUSTS § 197 cmt. b (1935). This is not to say that principles of contract law are irrelevant to the enforcement of the terms of the trust; rather, the issue concerns who the trier of fact – judge or jury – will be in resolving these disputes. See Langbein, *supra*, at 648-50.



further appellate review by the federal appellate courts, and ultimately by the Supreme Court.

A closely related argument to the cost-minimization policy is the risk that the possibility of additional monetary relief will perk the interest of the plaintiffs' tort bar and provide a financial incentive for more claims for wrongfully denied benefits to be filed on behalf of plan participants under Section 502(a)(1)(B). In and of itself, an increase in the number of such claims is not necessarily an undesirable outcome for the employee benefits system. The emergence of a plaintiffs' ERISA bar, and with it the possibility of more skillful challenges to wrongfully denied claims for plan benefits, would provide an incentive for plan administrators to improve the quality of their decision-making process in processing and reviewing claims for plan benefits.

Increased litigation certainly can lead to increased administrative costs. Some additional costs inevitably will result because, in a close case, the plan administrator may decide to approve the claim for benefits. The federal courts should not be concerned with this type of increased administrative cost, which implicitly reflects a balancing of numerous factors by the plan administrator. Such factors would include the cost of the claimed benefit, the merits of the participant's claim, the possible damages if the claim is denied and if the participant suffers personal injury or economic loss as a result, and the standard of judicial review under Section 502(a)(1)(B).

Some degree of additional administrative cost attributable solely to litigation expenses could result due to claims that are above the Rule 11 standard<sup>503</sup> for sanctions, but that are clearly not sufficient to overcome the *Firestone* abuse of discretion standard of judicial review for the plan administrator's decision.<sup>504</sup> These increased administrative costs can be curtailed by the federal courts through an award of attorney's fees to the plan administrator as the prevailing defendant in a Section 502(a)(1)(B) case. Such an attorney's fee award is expressly authorized by ERISA Section 502(g)(i), which provides that "the court in its discretion may allow a reasonable attorney's fee and costs of action to either party."<sup>505</sup> Although the current judicial practice in ERISA litigation is to award attorney's fees to a prevailing defendant only in rare instances, more frequent attorney's fees awards to a prevailing plan administrator would deter relatively weak claims under Section 502(a)(1)(B).

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503. FED. R. CIV. P. 11.

504. See *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 108–115 (1989) (outlining judicial standards for reviewing plan administrators' decisions).

505. 29 U.S.C. § 1132(g)(1) (2000) (emphasis added).

#### 4. Reconciling Prior Supreme Court Decisions with the Model Results and the ERISA Policy Triangle

Precedent is important for maintaining the stability of ERISA's voluntary system of employer-sponsored pension and welfare benefit plans. The Supreme Court's prior experience in successfully adopting a "fresh start" for judicial interpretation of another difficult statutory provision under title I of ERISA, the preemption of state law under Section 514(a),<sup>506</sup> provides encouraging evidence that a shift in the judicial approach to determining "appropriate equitable relief" under Section 502(a)(3) can be implemented without significant disruption to the employee benefit plan system.

Throughout the Article, I have attempted to demonstrate the points at which the results of the modeling exercise touched on prior Supreme Court precedents. The chart below summarizes the six categories of defendants and related claims generated by the modeling exercise, along with their corresponding Supreme Court precedents.

CATEGORY	DEFENDANT/CLAIM	SUPREME COURT CASE
I	Employee Benefit Plan/ Plan Design Requirements	<i>Heinz</i> (2004)
II	Employer /Retaliation  Employer/Improper Plan Amendment Procedure  Employer/Inurement of Plan Assets	<i>Inter-Modal</i> (1997)  <i>Curtiss-Wright</i> (1995)  <i>Hughes Aircraft</i> (1999)
III	Fiduciary/Breach of Fiduciary Responsibility	<i>Varity</i> (1996)
IV	Participant/Enforce Plan Terms	<i>Great-West</i> (2004) <i>Sereboff</i> (2006)
V	Party in Interest/Knowing Participation in a Breach of Fiduciary Duty or Prohibited Transaction	<i>Mertens</i> (1993) <i>Harris Trust</i> (2000)
VI	Third Party/Knowing Participation in a Breach of Fiduciary Duty or Prohibited Transaction or Violation of Plan Terms	None

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506. 29 U.S.C. § 1144(a)(2000).

Close examination of the Supreme Court decisions listed in the above chart shows that these prior precedents do not preclude the Supreme Court from adopting the fresh approach proposed in the Article. A few key points warrant further elaboration.

In *Mertens v. Hewitt Associates*,<sup>507</sup> the Supreme Court rejected what was essentially a request for a monetary award measured by a make-whole relief standard. The plaintiffs in *Mertens* sought a monetary award against the defendant actuarial firm that would restore the plan's funding deficit. Given that *Mertens* was a Category V claim against a nonfiduciary party in interest, the Supreme Court in *Mertens* correctly rejected a make-whole relief standard for monetary relief.<sup>508</sup> The ERISA Policy Triangle suggests that a restitution standard for monetary relief is the appropriate equitable remedy for a Category V claim against a nonfiduciary party in interest.<sup>509</sup>

*Harris Trust and Savings Bank v. Salomon Smith Barney*<sup>510</sup> also involved a Category V claim against a nonfiduciary party in interest. The parties in *Harris Trust* agreed that the plaintiffs requested remedies of "rescission of the transaction, restitution from [the defendant] Salomon of the purchase price with interest, and disgorgement of Salomon's profits made from use of the plan assets transferred to it" were all "equitable" within the meaning of Section 502(a)(3) as defined in *Mertens*.<sup>511</sup> All of these remedies focused on preventing the unjust enrichment of the defendant, and therefore are consistent with a restitution standard for a monetary award.

The Supreme Court has never addressed whether a make-whole relief standard for a monetary award is available under Section 502(a)(3) for a Category III claim against a fiduciary for breach of fiduciary responsibilities. In *Massachusetts Mutual Life Insurance Co. v. Russell*,<sup>512</sup> the issue of the remedies available under Section 502(a)(3) simply was not before the Supreme Court. In *Varity Corporation v. Howe*,<sup>513</sup> the Supreme Court's focus was on whether the plaintiffs' claim for individual relief was authorized by Section 502(a)(3).<sup>514</sup> The defendant in *Varity* had conceded that the remedy awarded to the plaintiffs by the district court was "equitable" under Section 502(a)(3).<sup>515</sup>

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507. 508 U.S. 248 (1993).

508. See *id.* at 250-51, 263.

509. See discussion *supra* Part III.D.3.a.

510. 530 U.S. 238 (2000).

511. *Id.* at 243.

512. 73 U.S. 134 (1985).

513. 516 U.S. 489 (1996).

514. See *id.* at 507-15.

515. See *id.* at 508.

Much of the Supreme Court's discussion in *Varity* concerning the validity of the plaintiffs' Category III claim under Section 502(a)(3) was centered around ERISA's grounding in the common law of trusts and ERISA's benefit-protection policy.<sup>516</sup> This discussion strongly suggests that a make-whole relief standard, a standard that originated under the common law of trusts for a trustee's breach of fiduciary duty, is the appropriate measure for a monetary award for a Category III claim.<sup>517</sup>

*Great-West Life & Annuity Insurance Co. v. Knudson*<sup>518</sup> suggested that the equitable lien and the constructive trust are available as forms of equitable restitution under Section 502(a)(3),<sup>519</sup> and *Sereboff v. Mid Atlantic Medical Services, Inc.*<sup>520</sup> explicitly verified this conclusion.<sup>521</sup> Both the equitable lien and the constructive trust are restitutionary devices designed to prevent the unjust enrichment of the defendant.<sup>522</sup> These remedies are consistent with ERISA's balancing of policy interests for claims against participants (Category IV), claims against a nonfiduciary party in interest (Category V), and claims against third parties (Category VI).

The majority and dissenting opinions in *Great-West* also debated the implications of equitable relief under Section 502(a)(3) for a Category II claim for unlawful retaliation under Section 510.<sup>523</sup> This debate was premature, and could easily be dismissed in a subsequent opinion as yet another instance where the Supreme Court was merely "flagging the issue" of possible remedies available under Section 502(a)(3).<sup>524</sup>

In short, *stare decisis* is not an insurmountable obstacle to resolving the judicial paradox of "equitable" relief under Section 502(a)(3). The Supreme Court may adopt a fresh approach to judicial interpretation of the claims and remedies available under Section 502(a)(3), while at the same time preserving the core of its prior precedents.

#### IV. CONCLUSION

A better theory for determining "appropriate equitable relief" under Section 502(a)(3) of ERISA is sorely needed. The Supreme

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516. See *id.* at 507-15.

517. See discussion *supra* Part III.D.3.a.

518. 534 U.S. 204 (2002).

519. See *id.* at 213-14.

520. 126 S. Ct. 1869 (2006).

521. See *id.* at 1875.

522. See discussion *supra* Part III.D.3.c.

523. Compare *Great-West*, 534 U.S. at 218, n. 4 (Scalia, J.) (discussing equitable relief), with *Great-West* at 230, n. 2 (Ginsburg, J., dissenting) (discussing equitable relief).

524. See *Harris Trust & Sav. Bank v. Salomon Smith Barney*, 530 U.S. 238, 249 (2000) (correcting prior erroneous dictum in *Mertens*).

Court's law-equity paradigm negates ERISA's protections for plan participants, thereby eroding the confidence of employees in the modern employee benefits system. The law-equity paradigm simultaneously discourages employers from offering benefits to their employees by making their benefit plans more costly to sponsor and administer. Ultimately, the law-equity paradigm has led to judicial decisions under Section 502(a)(3) that contravene Congress's intent to provide a uniform body of federal standards to govern employee benefit plans upon which plan participants and employers alike can depend.

Rather than looking to Congress for a solution, the Supreme Court should acknowledge that relying upon the traditional distinctions between remedies available at law and in equity has produced less than satisfactory results for claims brought under Section 502(a)(3) of ERISA. Just as the Supreme Court has modified its approach to interpreting ERISA preemption of state law under Section 514(a), the Supreme Court should adopt a fresh approach to interpretation of "appropriate equitable relief" available under Section 502(a)(3).

This Article presents an alternative statutory and policy-based theory for judicial interpretation of the remedies authorized by Section 502(a)(3). The Article demonstrates how the Supreme Court may, consistent with the statutory scheme and the Court's own prior precedents, use this proposed alternative theory to resolve the judicial paradox of "equitable" relief available under Section 502(a)(3).

The statutory and policy-based theory described in the Article further provides a starting point for Congress, if it so chooses, to develop legislation to modernize the private civil claims and remedies available under title I of ERISA. When ERISA was enacted in 1974, it was reasonable for Congress to frame Section 502(a)(3) as a catch-all remedies provision to deal with unanticipated claims and remedies that inevitably would arise under the newly created federal system of regulation for employee benefit plans. Now, with the benefit of over thirty years of experience, Congress is sufficiently informed to once again take up the issue of ERISA claims and remedies in light of the modern world of retirement and health care plans. As discussed in Part II of the article, this modern world looks very different than the system that existed in 1974.

Whether Congress has the political will to take up this task, however, is less clear. The preferred approach, advocated by this Article, is for the Supreme Court itself to resolve the judicial paradox of "equitable" relief under Section 502(a)(3).

## APPENDIX A

## FEDERAL COMMON LAW CLAIMS UNDER SECTION 502(A)(3)

In conducting the modeling exercise, I excluded federal common law claims from the universe of possible claims that could be brought under Section 502(a)(3). My reasons for excluding federal common law claims were based on the statutory language and structure and the potential implications for the doctrine of complete preemption. Upon closer examination of various types of federal common law claims, I further concluded that such claims are either unnecessary or an illegitimate attempt to circumvent the statutory scheme of fiduciary liability established by title I of ERISA.

## a. Statutory Language

The statutory text underlying Section 502(a)(3) was my first reason for excluding federal common law claims. The language of Section 502(a)(3) is clear that the nature of the claim must be limited to a violation of a statutory provision of title I of ERISA or a violation of plan terms.<sup>1</sup> Thus, the plain language of the statute appeared to preclude any claim not founded expressly on one of these two bases.

To confirm this reading of the statutory text, I examined the legislative history of ERISA and concluded that it does not support the assertion that Section 502(a)(3) creates federal common law claims. Rather, the focus of the legislative history is on the development of *remedies* by the federal courts, particularly in the context of claims for breach of ERISA fiduciary responsibilities.<sup>2</sup>

This interpretation of Section 502(a)(3) as precluding implied federal common law claims is consistent with statements made by the Supreme Court in *Massachusetts Mutual Life Insurance Co. v. Russell*<sup>3</sup> and *Mertens v. Hewitt Associates*.<sup>4</sup> In *Russell*, the Supreme Court rejected the possibility that a cause of action could be implied under Section 502(a)(2) of ERISA, explaining that:

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1. 29 U.S.C. § 1132(a)(3) (2000).

2. See H.R. REP. NO. 93-533 (1973), *reprinted in* 1974 U.S.C.C.A.N. at 4639, 4655 (“The enforcement provisions have been designed specifically to provide both the Secretary and participants and beneficiaries with broad remedies for redressing or preventing violations of the Act. . . [and] provide the full range of legal and equitable remedies available in both state and federal courts and to remove jurisdictional and procedural obstacles.”); S. REP. NO. 93-127 (1973), *reprinted in* 1974 U.S.C.C.A.N. at 4838, 4871 (stating the same purpose as its counterpart in the House).

3. 473 U.S. 134 (1985).

4. 508 U.S. 248 (1993).

[t]he six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted, however, provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly. The assumption of inadvertent omission is rendered especially suspect upon close consideration of ERISA's interlocking, interrelated, and interdependent remedial scheme, which is in turn part of a "comprehensive and reticulated statute." We are reluctant to tamper with an enforcement scheme crafted with such evident care as the one in ERISA.<sup>5</sup>

In *Mertens*, the Supreme Court affirmed that the reasoning of *Russell* applied with equal force under Section 502(a)(3).

In *Russell* we emphasized our unwillingness to infer causes of action in the ERISA context, since that statute's carefully crafted and detailed enforcement scheme provides "strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly."<sup>6</sup>

b. The Complete Preemption Doctrine and Implied Claims Under Section 502(a)(3)

My second reason for excluding federal common law claims from the modeling exercise was based on the potential implications for the doctrine of complete preemption. Normally, the well-pleaded complaint rule bars removal of a state law claim filed in state court to federal court where a federal question is not present on the face of the plaintiff's complaint.<sup>7</sup> The doctrine of complete preemption recognizes as an exception to the well-pleaded complaint rule "that Congress may so completely pre-empt a particular area that any civil complaint raising this select group of claims is necessarily federal in character," and therefore removal to federal court is appropriate based on federal question jurisdiction.<sup>8</sup>

Complete preemption issues arise when the plaintiff is asserting a state law claim that could be asserted under one of the civil enforcement provisions of Section 502(a) of ERISA.<sup>9</sup> To date, the Supreme Court has addressed the doctrine of complete preemption under ERISA only in the context of state law claims that could have been brought as claims asserting a wrongful

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5. *Russell*, 473 U.S. at 146-47 (italics in original) (quoting *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 361 (1980)).

7. See *Louisville & Nashville R. Co. v. Mottley*, 211 U.S. 149, 153 (1908).

8. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-64 (1987).

9. 29 U.S.C. § 1132(a)(2) (2000); see *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004) (stating that any state law claim that duplicates the ERISA civil enforcement remedy is pre-empted because it conflicts with Congress' intent to make the ERISA remedy exclusive).

denial of plan benefits under Section 502(a)(1)(B).<sup>10</sup> The Supreme Court has yet to directly address the doctrine of complete preemption in the context of state law claims that could have been brought under Section 502(a)(3).

In *Ingersoll-Rand Co. v. McClendon*,<sup>11</sup> the Supreme Court suggested that, if squarely faced with the issue, the Court would rule that the doctrine of complete preemption also applied to claims under Section 502(a)(3). The *Ingersoll-Rand* Court relied in part upon Section 502(a)(3) for support of its conclusion that Section 514(a) of ERISA<sup>12</sup> preempted a wrongful discharge claim under Texas state law. The Supreme Court reasoned that the state law claim “conflicted” with a Section 510 claim for retaliation, a violation which gives rise to a claim under Section 502(a)(3).<sup>13</sup> The Supreme Court in *Ingersoll-Rand* emphasized the exclusive jurisdiction of the federal courts to hear claims under Section 502(a)(3), and also cited *Metropolitan Life Ins. Co. v. Taylor*<sup>14</sup> as further support for its preemption analysis.<sup>15</sup>

Unfortunately, the Supreme Court’s written opinion in *Ingersoll-Rand* lacked the magical words “complete preemption.” The lower federal circuits subsequently have become divided over whether the doctrine of complete preemption applies to a state law claim that could have been brought as a claim under Section 502(a)(3).<sup>16</sup>

The case for application of the complete preemption doctrine in the Section 502(a)(3) setting appears to be even more compelling than for Section 502(a)(1)(B) claims. Section 502(e)(1) of ERISA,<sup>17</sup> which grants the federal courts *exclusive* subject matter jurisdiction over Section 502(a)(3) claims, indicates that a state law claim filed in state courts that could have been brought as a claim under Section 502(a)(3) is removable to federal court under the complete preemption doctrine. Quite simply, why would Congress choose to completely preempt claims under Section 502(a)(1)(B), over which state and federal courts have dual subject

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10. 29 U.S.C. § 1132(a)(1)(B) (2000); see *Davila*, 542 U.S. at 209; *Taylor*, 481 U.S. at 62-63.

11. 498 U.S. 133, 145 (1990).

12. 29 U.S.C. § 1144(a) (2000).

13. *Ingersoll-Rand*, 498 U.S. at 142-45.

14. 481 U.S. 58, 63-64 (1987).

15. *Ingersoll-Rand*, 498 U.S. at 144-45.

16. Compare *Wood v. Prudential Ins. Co. of Am.*, 207 F.3d 674, 678 (3d Cir. 2000) (holding that complete preemption applies to a claim under Section 510) and *Anderson v. Elec. Data Systems Corp.*, 11 F.3d 1311, 1315 (5th Cir. 1994) (stating that complete preemption applies to claims under Sections 502(a)(2) and 502(a)(3)) with *Lupo v. Human Affairs Int’l, Inc.*, 28 F.3d 269, 273 (2d Cir. 1994) (stating that complete preemption is limited to claims under Section 502(a)(1)(B)).

17. 29 U.S.C. § 1132(e)(1) (2000).



matter jurisdiction under Section 502(e)(1), and yet not intend to completely preempt claims under Section 502(a)(3), over which the federal courts have exclusive subject matter jurisdiction?

The better statutory interpretation, based on Congress's grant of exclusively federal subject matter jurisdiction over claims brought under Section 502(a)(3), is to apply the doctrine of complete preemption to Section 502(a)(3) claims. Adding federal common law claims to the universe of possible Section 502(a)(3) claims, therefore, potentially would expand the number and types of state law-based claims, originally filed in state courts, that a state court defendant could remove to federal court under the doctrine of complete preemption. The potential for unwarranted judicial expansion of the doctrine of complete preemption provided further support for excluding federal common law claims from the universe of possible claims under Section 502(a)(3).

c. Unnecessary or Illegitimate Federal Common Law Claims

My third reason for excluding the federal common law claims from the modeling exercise was based on a close examination of several of the more prevalent types of federal common law claims that have been asserted in federal court litigation. The federal common law claims I examined were:

- (i) equitable estoppel;
- (ii) specific performance;
- (iii) vicarious (respondeat superior) liability; and
- (iv) contribution or indemnification against a person who is not a fiduciary.

For the reasons discussed below, none of these federal common law claims presented a persuasive case for recognizing federal common law claims under Section 502(a)(3).

i. *Equitable Estoppel*

The federal common law claim of equitable estoppel originated prior to the Supreme Court's decision in *Varity Corp. v. Howe*.<sup>18</sup> Prior to *Varity*, it was unclear whether a breach of fiduciary duty claim could be brought for individual (as opposed to plan-wide) relief under Section 502(a)(3).<sup>19</sup> Post-*Varity*, the

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18. 516 U.S. 489 (1996).

19. *Slice v. Sons of Norway*, 34 F.3d 630, 635 (8th Cir. 1994) (finding that employee failed to state a claim for equitable estoppel in a claim adjustment of

fiduciary's duty to act prudently in providing information to plan participants concerning the administration of the plan and its benefits provides a statutory basis under Section 404(a)(1)(B)<sup>20</sup> for pleading this type of claim as a breach of the fiduciary's statutory duty of prudence.<sup>21</sup>

More recent cases addressing equitable estoppel under Section 502(a)(3) have characterized equitable estoppel as a *remedy* available under Section 502(a)(3), rather than as a federal common law *claim*.<sup>22</sup> The purpose of characterizing equitable estoppel as an equitable remedy under Section 502(a)(3) is to avoid the paradoxical result that an adequate remedy otherwise may not be available under Section 502(a)(3) for the plaintiff's injury. Resolving the judicial paradox of equitable remedies under Section

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benefits after computation error overpaid benefits because the employee failed to establish that the estoppel would merely hold his employer to a plausible interpretation of the plan, rather than a modification); *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54, 60-61 (4th Cir. 1992) (finding that employee's suit for employer's non-payment of benefit premiums could not be based on estoppel because it was preempted); *Miller v. Coastal Corp.*, 978 F.2d 622, 624-25 (10th Cir. 1992) (holding that employee's claim that oral and written representations, regarding credited service under pension plan failed because an employee benefit plan could not be modified by informal communications); *Cefalu v. B.F. Goodrich Co.*, 871 F.2d 1290, 1295 (5th Cir. 1989) (finding that employee had no cause of action for estoppel in a breach of contract where state employee benefits were preempted by ERISA); *Degan v. Ford Motor Co.* 869 F.2d 889, 894 (5th Cir. 1989) (holding that ERISA preempted employees' suit for breach of oral contract to pay early retirement benefits, and did not allow an estoppel claim); *Straub v. Western Union Tel. Co.*, 851 F.2d 1262, 1265-66 (10th Cir. 1988) (holding that estoppel did not encompass oral representations regarding the continuation of benefit plan under a partnership sale because Congress did not intend for ERISA to incorporate state law promissory estoppel); *Davidian v. S. Cal. Meat Cutters Union & Food Emp. Benefit Fund*, 859 F.2d 134, 136 (9th Cir. 1988) (rejecting employee's estoppel claims in a suit for payment of major medical benefits for surgery). *See generally*, COLLEEN E. MEDILL, INTRODUCTION TO EMPLOYEE BENEFITS LAW: POLICY AND PRACTICE, 72-77 (2004) (summarizing the various circuit approaches to estoppel claims).

20. 29 U.S.C. § 1104(a)(1)(B) (2000).

21. *See Varsity*, 516 U.S. at 502-03, 506-07 (discussing nature of ERISA fiduciary communications and remedies for individual beneficiaries); *see also* discussion *supra* Article Part III C.3.c.ii. (discussing the parameters of the fiduciary duty to inform).

22. The Third Circuit has expressly stated that it views equitable estoppel as an additional remedy to the three equitable remedies of mandamus, injunctive relief, and restitution identified in *Mertens*. In *re Unisys Corp. Retiree Medical Ben. ERISA Litig.*, 58 F.3d 896, 907 n.22 (3d Cir. 1995). The Second Circuit also appears to view equitable estoppel as an appropriate equitable remedy under Section 502(a)(3) after *Mertens*. *See Devlin v. Empire Blue Cross and Blue Shield*, 274 F.3d 76, 88-89 (2d Cir. 2001). The Ninth Circuit views *Mertens* as precluding an equitable estoppel remedy under Section 502(a)(3). *Watkins v. Westinghouse Handford Co.*, 12 F.3d 1517, 1527-28 (9th Cir. 1993).

502(a)(3) by permitting make-whole relief for a breach of fiduciary duty claim, a proposed solution that I discuss in Part III.D.3.a. of the Article, eliminates the need for equitable estoppel as a remedy as well.

ii. *Specific Performance*

Prior to the Supreme Court's decision in *Great-West Life and Annuity Insurance Co. v. Knudson*,<sup>23</sup> plan administrators attempted to assert the federal common law claim of specific performance under Section 502(a)(3) as a means to enforce the terms of a plan reimbursement clause against a plan participant.<sup>24</sup> Characterizing the claim as one for specific performance (an equitable theory under the law of contracts) neatly circumvented the "rule" of *Mertens v. Hewitt Associates*<sup>25</sup> that an award of money damages was a form of *legal* relief not available under Section 502(a)(3).<sup>26</sup>

The majority opinion in *Great-West* appears to dismiss "specific performance of a past due monetary obligation" as a remedy not "typically" available in equity, and therefore not available as a remedy under Section 502(a)(3).<sup>27</sup> The Supreme Court's subsequent decision in *Sereboff v. Mid Atlantic Medical Services, Inc.*<sup>28</sup> enables plan administrators to enforce the terms of a plan reimbursement clause using the equitable remedy of an equitable lien or a constructive trust.<sup>29</sup> If construed in a flexible manner by the federal courts, permitting an equitable lien or a constructive trust as an equitable remedy under Section 502(a)(3) will eliminate the need for a plan administrator to assert a federal common law claim of specific performance. Instead, the plan administrator may assert a claim to enforce the terms of the plan, a claim that is expressly authorized by the plain language of Section 502(a)(3).

iii. *Vicarious (Respondeat Superior) Fiduciary Liability*

Another prevalent federal common law claim is the vicarious (respondeat superior) fiduciary liability claim. Under the common law, "*respondeat superior* is a 'judge-made doctrine, applicable to most tort cases. . . , that makes an employer liable even if faultless

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23. 534 U.S. 204 (2002).

24. See *Administrative Comm. v. Gauf*, 188 F.3d 767, 770-71 (7th Cir. 1999); *Blue Cross and Blue Shield of Ala. v. Sanders*, 138 F.3d 1347, 1353 n.5 (11th Cir. 1998).

25. 508 U.S. 248 (1993).

26. See *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 218 (2002).

27. *Id.* at 211-12.

28. 126 S.Ct.1869 (2006).

29. See *id.* at 1875.

for the torts its employees commit in the course of their employment.”<sup>29</sup> In the ERISA context, a vicarious fiduciary liability claim is asserted as a means of making a person (the “principal”), who is not otherwise a fiduciary with respect to a plan, liable for a breach of fiduciary duty under ERISA committed by an agent of the principal.

Vicarious fiduciary liability has become a fashionable claim in litigation concerning company stock held in the employer’s 401(k) plan. In these 401(k) plan cases, the implied claim asserted under Section 502(a)(3) is that the company who sponsors the plan is liable as an entity under a theory of vicarious fiduciary liability for the actions of a company director, officer, or employee who is a plan fiduciary and who breached a fiduciary duty under ERISA.<sup>31</sup>

Vicarious fiduciary liability claims are possible in a variety of factual circumstances<sup>32</sup> and the case law in this area is still

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29. *Howell v. Motorola, Inc.*, 337 F.Supp. 2d 1079, 1093 (N.D. Ill. 2004) (quoting *Gernetzke v. Kenosha Unified Sch. Dist. No. 1*, 274 F.3d 464, 467-68 (7th Cir. 2001)).

31. See eg., *DiFelice v. US Airways, Inc.*, 397 F. Supp. 2d 758 (E.D. Va. 2005); *In re Westar Energy, Inc., ERISA Litig.*, No. 03-4032, 2005 WL 2403832 (D. Kan. Sept. 29, 2005); *Pietrangelo v. NUI Corp.*, No. 04-3223, 2005 WL 1703200 (D.N.J. July 20, 2005); *In re Sprint Corp. ERISA Litig.*, 388 F.Supp. 2d 1207 (D. Kan. 2004); *Howell*, 337 F.Supp. 2d 1079; *In re Reliant Energy ERISA Litig.*, 336 F.Supp. 2d 646 (S.D. Tex. 2004); *In re AEP ERISA Litig.*, 327 F.Supp. 2d 812 (S.D. Ohio 2004); *Kling v. Fidelity Mgmt. Trust Co.*, 323 F.Supp. 2d 132 (D. Mass. 2004); *In re Elec. Data Sys. Corp. “ERISA” Litig.*, 305 F.Supp. 2d 658 (E.D. Tex. 2004); *In re Enron Corp. Sec., Derivation & ERISA Litig.*, 284 F.Supp. 2d 511 (S.D. Tex. 2003); *In re Worldcom, Inc. ERISA Litig.*, 263 F.Supp. 2d 745 (S.D.N.Y. 2003) (allowing plaintiffs to raise vicarious liability causes of action).

32. See *Hamilton v. Carell*, 243 F.3d 992, 1001-03 (6th Cir. 2001) (finding that defendant corporation and individual comptroller who made investments for the plaintiff’s trust fund could not be held liable for breach of fiduciary duty because those actions were outside the scope of discretionary acts of the plan administration under ERISA); *Nat’l Football Scouting, Inc. v. Cont’l Assurance Co.*, 931 F.2d 646, 649 (10th Cir. 1991) (finding that lower court erred in holding that defendant individual was not an agent of the defendant corporation, who converted funds that were entrusted to it by the plaintiff for a pension investment fund); *Am. Fed’n. of Unions Local 1002 Health & Welfare Fund v. Equitable Life Assurance Soc’y*, 841 F.2d 658, 663 (5th Cir. 1988) (finding insurance agent who was serving as administrator of plaintiff’s fund liable as fiduciary for claims paid to ineligible people and commissions on illegitimate claims approved); *In re Mut. Funds Inv. Litig.*, 403 F. Supp. 2d 434, 448 (D. Md. 2005) (holding that denial of fiduciary duty under respondeat superior was an inappropriate affirmative defense at motion to dismiss stage, but that such a defense would be unlikely); *Crowley v. Corning, Inc.*, 234 F.Supp. 2d 222, 228-29 (W.D.N.Y. 2002) (finding sponsor of stock had no responsibility to administer the plan and no fiduciary duty to the retiree-plaintiff); *Tool v. Nat’l Employee Benefit Services, Inc.* 957 F.Supp. 1114, 1121 (N.D. Cal. 1996) (holding that to expand the definition of fiduciary to include insurance company on respondeat superior contradicted strict constructions of ERISA liability provisions).

nascent. An examination of this developing body of law reveals that vicarious fiduciary liability claims appear to cluster in two groups. Many vicarious fiduciary liability claims appear to be unnecessary because these claims can be recast as statutory claims under title I of ERISA. A claim can be recast either as a breach of the fiduciary's duty to prudently select and monitor individuals (whether fiduciaries or not) who assist in the administration of the plan under Section 404(a)(1)(B),<sup>33</sup> or as a breach of a co-fiduciary duty under Section 405.<sup>34</sup> These statutory-based claims for breach of fiduciary and co-fiduciary duties often are made in conjunction with vicarious fiduciary liability claims.<sup>35</sup>

A vicarious fiduciary liability claim provides an alternative basis for liability if the federal court determines that the principal is not a fiduciary with respect to the plan, and therefore cannot be liable for a breach of fiduciary or co-fiduciary duty. When the principal is found not to be a fiduciary with respect to the plan, however, a vicarious fiduciary liability claim functions as a strategic subterfuge to impose ERISA fiduciary liability upon the nonfiduciary principal.<sup>36</sup> In this situation, the vicarious fiduciary liability claim is an illegitimate attempt to circumvent the system of fiduciary liability that Congress carefully crafted in designing the fiduciary conduct and liability rules of title I of ERISA.<sup>37</sup>

*iv. Contribution and Indemnification Against a Nonfiduciary*

Claims under Section 502(a)(3) for contribution or indemnification brought by a plan fiduciary against a person who is not a fiduciary under ERISA provide yet another example where the plaintiff seeks to gain more federal rights than Congress intended to create under ERISA. To understand why this is so, it is helpful to step back and first view these claims in the greater context of claims for contribution and indemnification among co-fiduciaries that are brought under Section 502(a)(2).<sup>38</sup>

When one fiduciary of the plan sues a co-fiduciary for contribution or indemnification, Section 502(a)(2) controls such claims. The federal courts are divided over whether ERISA

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33. 29 U.S.C. § 1104(a)(1)(B) (2000); see *Leigh v. Engle*, 727 F.2d 113, 135 (7th Cir. 1984) (stating that fiduciaries responsible for selecting and retaining plan administrators have a duty to monitor the actions of the administrators).

34. 29 U.S.C. § 1105 (2000).

35. See *Bannistor v. Ullman*, 287 F.3d 394, 407-08 (5th Cir. 2002) (noting that the two claims are often brought together); *Howell*, 337 F.Supp. 2d at 1092-95; *Kling*, 323 F.Supp. 2d at 141-45.

36. See 29 U.S.C. § 1002(21)(A) (2006) (defining fiduciary); *Hamilton*, 243 F.3d at 1001-03; *Howell*, 337 F. Supp.2d at 1093-95; *Kling*, 323 F. Supp. 2d at 145-47.

37. See *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 261-63 (1993) (rejecting that an implied federal common law claim of vicarious fiduciary liability).

38. 29 U.S.C. § 1132(a)(2) (2000).

permits federal common law claims for contribution and indemnification among co-fiduciaries under Section 502(a)(2).<sup>39</sup> The case for contribution and indemnification claims among co-fiduciaries under Section 502(a)(2) appears to lack substantial support in the statutory language of title I of ERISA and its legislative history.<sup>40</sup> Although such claims among co-trustees were permitted under the common law of trusts, there are compelling policy reasons to disallow co-fiduciary claims for contribution and indemnification under ERISA.<sup>41</sup>

These claims among co-fiduciaries under Section 502(a)(2) provide the context for analyzing the question of whether a fiduciary may bring a federal common law claim for contribution or indemnification against a *nonfiduciary* under Section 502(a)(3). At least one federal circuit has suggested that a fiduciary may bring a claim for contribution or indemnification against a nonfiduciary under Section 502(a)(3).<sup>42</sup>

Given the fact that the case for contribution and indemnification claims among co-fiduciaries is weak,<sup>43</sup> a claim against a *nonfiduciary* for contribution or indemnification under Section 502(a)(3) is even weaker. As with vicarious fiduciary liability claims, permitting a federal common law claim under Section 502(a)(3) for contribution and indemnification by a fiduciary against a nonfiduciary would negate the system of fiduciary liability that Congress carefully crafted in designing the fiduciary conduct and liability rules of title I of ERISA.<sup>44</sup>

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39. Compare *Chemung Canal Trust Co. v. Sovran Bank/Md.*, 939 F.2d 12, 20 (2d Cir. 1991) (finding that incorporating doctrines of contribution and indemnity was appropriate) and *Free v. Briody*, 732 F.2d 1331, 1337 (7th Cir. 1984) with *Call v. Sumitomo Bank of Cal.*, 881 F.2d 626, 631 (9th Cir. 1989) (finding a contribution claim in favor of breaching fiduciary inappropriate).

40. See George Lee Flint, Jr. & Philip W. Moore, Jr., *ERISA: A Co-Fiduciary Has No Right to Contribution and Indemnity*, 48 S.D. L. REV. 7, 48-50 (2003).

41. See Flint & Moore, *supra* Appendix A note 40, at 27-29, 50 (discussing that allowing contribution and indemnity would interfere with the risk allocation system set up by Congress).

42. See *McDannold v. Star Bank, N.A.*, 261 F.3d 478, 485-87 (6th Cir. 2001) (noting that there is a circuit split as to whether a fiduciary may bring a claim against a nonfiduciary).

43. After an exhaustive review of all relevant material on the topic, Flint and Moore conclude, in a compelling fashion, that ERISA should not permit claims for contribution and indemnification among co-fiduciaries. See Flint & Moore, *supra* Appendix A note 40, at 51 (noting that ERISA differs considerably from traditional trust law). Rather than repeating their comprehensive analysis here, I urge the reader to read their original article.

44. Flint & Moore, *supra* Appendix A note 40, at 50; see also *Mertens v. Hewitt Associates*, 508 U.S. 248, 261-263 (1993) (noting that ERISA eliminated joint and several liability to reduce high insurance costs on ERISA plans).

## APPENDIX B

## THE PROBLEM OF INTERTWINED FIDUCIARY CLAIMS

To determine the potential impact of the problem of intertwined fiduciary claims on the modeling exercise, I focused on the following two questions:

- (1) Why does a breach of fiduciary duty claim become intertwined with the other four groups of claims that are possible under Section 502(a)(3)?
- (2) What makes a breach of fiduciary duty claim distinct from each of the other four groups of claims that are possible under Section 502(a)(3)?

My analysis and conclusions concerning these two questions are described below.

a. Intertwined Group 1 Claims

Breach of fiduciary duty claims can become intertwined with Group 1 claims because enforcement or implementation by a fiduciary of a plan term that is illegal under ERISA's statutory plan design requirements is itself a breach of the fiduciary's duty of prudence. Enforcement or implementation of an illegal plan term also is a breach of the fiduciary duty to disregard plan terms that are inconsistent with the statutory provisions of title I of ERISA.<sup>1</sup> Therefore, a breach of duty claim against a fiduciary who administers an illegal plan term may accompany a Group 1 claim challenging the legality of the plan term itself.

In these circumstances, the breach of fiduciary duty claim is distinct from the Group 1 claim. The Group 1 claim challenges the design of the plan itself as illegal under the statutory plan design requirements of Title I of ERISA. In contrast, the breach of fiduciary duty claim challenges the conduct of the plan fiduciary who administers the illegal plan term when, under Section 404(a)(1)(D), the fiduciary had an affirmative fiduciary duty to disregard it.<sup>2</sup>

Decisions by the *employer* concerning the design of the plan are, under the settlor function doctrine, not subject to judicial scrutiny as fiduciary conduct.<sup>3</sup> Therefore, the employer's decisions concerning plan design must be challenged directly as a Group 1

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1. 29 U.S.C. § 1104(a)(1)(D) (2000).

2. *Id.*

3. See discussion *supra* Article Part III.D.1.

claim under title I of ERISA, or challenged indirectly through a Group 3 claim for breach of fiduciary duty.

b. Intertwined Group 2 Claims

The types of claims in Group 2 may require the cooperation of a fiduciary to implement fully the employer's illegal conduct that gives rise to the Group 2 claim. The fiduciary's cooperation in the employer's illegal act or conduct would result in the intertwining of breach of fiduciary duty claims with Group 2 claims. For example, the cooperation of the plan's fiduciary administrator is necessary to deny plan benefits to a participant as part of an illegal retaliatory employment action by the employer under Section 510.<sup>4</sup> The cooperation of the plan's administrator is necessary to implement and administer an employer amendment that was not enacted in accordance with the plan's stated amendment procedure.<sup>5</sup> Similarly, the cooperation of the plan's fiduciary trustee is necessary for the employer to access the plan's assets and use or distribute those assets for the benefit of the employer in violation of the anti-inurement clause.<sup>6</sup>

In each of these situations, the breach of fiduciary duty claim is distinct from the Group 2 claim. Group 2 claims are based on statutory provisions that regulate the conduct of the employer when the employer is *not* acting as a fiduciary. Group 2 claims are unique under title I of ERISA because these claims can be brought directly against the employer when the employer is *not* acting in a fiduciary capacity with respect to the plan.<sup>7</sup> In contrast, a breach of fiduciary duty claim targets the fiduciary's actions in cooperating with and facilitating the employer's illegal conduct.

c. Intertwined Group 4 Claims

A Group 4 claim for a violation of the prohibited transaction rules may become intertwined with a breach of fiduciary duty claim in two distinct situations. The first situation focuses on the fiduciary with authority to cause the plan to engage in a transaction involving plan assets (the "authorizing fiduciary"). The party in interest prohibited transaction rules prohibit the authorizing fiduciary from causing the plan to engage in a transaction if the fiduciary "knows or should know" that such

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4. See 29 U.S.C. § 1140 (2000) (stating that interference with a beneficiary of an employee benefit plan's protected rights is unlawful).

5. See 29 U.S.C. § 1102(b)(3) (2000) (requiring every employee benefit plan to "provide a procedure for amending such plan, and for identifying the persons who have authority to amend the plan").

6. See 29 U.S.C. § 1103(c)(1) (2000) (assets of the plan shall be held for the exclusive benefit of participants).

7. See discussion *supra* Article Part III.B.2. (discussing Group 2 claims).



transaction constitutes a direct or indirect violation of the prohibited transaction rules of Section 406(a)(1).<sup>8</sup>

If, despite this prohibition, the authorizing fiduciary causes the plan to engage in a transaction that is prohibited under Section 406(a), two intertwined claims arise under Section 502(a)(3). A Group 4 claim exists against the party in interest who engaged in the prohibited transaction with the plan.<sup>9</sup> In addition, if the authorizing fiduciary knew or should have known that the transaction was prohibited, then the authorizing fiduciary has, at a minimum, violated the fiduciary duty of prudence under Section 404(a)(1)(B).<sup>10</sup>

In this situation, the two claims are distinguishable. The Group 4 claim focuses on the conduct of the party in interest as the defendant. In contrast, the breach of fiduciary duty claim focuses on the lack of prudence by the authorizing fiduciary in authorizing the plan to enter into the prohibited transaction in the first place.

The second situation, where a Group 4 claim and a breach of fiduciary duty claim may become intertwined, involves a violation of the fiduciary prohibited transaction rules of Section 406(b).<sup>11</sup> Here, *any* fiduciary of the plan (not just a fiduciary with the authority to authorize transactions involving plan assets) is prohibited from self-dealing with plan assets, from transacting with the plan on behalf of another party whose interests are adverse to the interests of the plan, or from personally receiving kickbacks from a party who has transacted with the plan.<sup>12</sup>

In this second situation, the Group 4 claim may become intertwined with a claim for breach of the fiduciary's duty of loyalty under Section 404(a)(1)(A).<sup>13</sup> In this example, the *same conduct* by the fiduciary defendant may give rise to both a breach of fiduciary duty claim and a Group 4 claim for violation of the fiduciary prohibited transaction rules of Section 406(b).

In my example, these two claims nevertheless are distinctly different in terms of the legal standard for adjudicating liability. In a Group 4 claim for a violation of the fiduciary prohibited transaction rules, if the facts of the transaction are proven, the fiduciary is liable *per se* even if the transaction did not cause injury to the plan.<sup>14</sup> A breach of fiduciary duty claim is different in

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8. 29 U.S.C. § 1106(a) (2000).

9. *Harris Trust & Sav. Bank v. Salomon Smith Barney*, 530 U.S. 238, 246 (2000).

10. *See* 29 U.S.C. § 1104(a)(1)(B) (2000).

11. 29 U.S.C. § 1106(b) (2000).

12. *See* 29 U.S.C. § 1106(b)(1)-(3).

13. 29 U.S.C. § 1104(a)(1)(A) (2000).

14. *See* AMERICAN BAR ASS'N, *EMPLOYEE BENEFITS LAW* 720-21 (2d ed. 2000) (discussing prohibited transactions under ERISA); *Donovan v. Cunningham*, 716 F.2d 1455, 1464-66 (5th Cir. 1983) (stating purpose of

that the plaintiff asserting the claim must prove that the fiduciary's unlawful conduct caused injury to the plan or to a plan participant.<sup>15</sup> I concluded that the element of causation was sufficient justification to retain the distinction.

d. Intertwined Group 5 Claims

Group 5 claims for a violation of plan terms may become intertwined with breach of fiduciary duty claims because Section 404(a)(1)(D) requires a fiduciary to discharge his duties "in accordance with the documents and instruments governing the plan," but only "insofar as such documents and instruments are consistent with the [statutory] provisions of [title I of ERISA]."<sup>16</sup> Section 404(a)(1)(D) creates a dual duty for the fiduciary when administering the terms of the plan. The fiduciary has an affirmative duty to follow the terms of the plan that are consistent with the statutory requirements of title I of ERISA. At the same time, the fiduciary has an affirmative duty to disregard those plan terms that are contrary to the statutory requirements of title I of ERISA.<sup>17</sup>

An illustration of this double-edged fiduciary duty is a retirement plan with an investment policy that authorizes the fiduciary to invest plan assets in the stock of the company who sponsors the plan. For example, assume the plan's investment policy requires the fiduciary to invest employer contributions to the plan in company stock. The fiduciary may conclude that following the terms of the plan violates the fiduciary's duties of prudence, loyalty, or prudent diversification, and refuse to follow the terms of the plan. Such a refusal may give rise to a claim for breach of the fiduciary's duty to follow the terms of the plan. Alternatively, the fiduciary may decide to follow the terms of the plan. Later, after the plan has suffered an investment loss due to a decline in the market value of the company stock, this decision may give rise to a claim for breach of the fiduciary's duty to disregard the plan terms under Section 404(a)(1)(D).

In my investment policy example, the terms of the plan are unambiguous and leave no room for discretionary interpretation by the fiduciary. Group 5 claims also can involve the plan fiduciary's discretionary authority to interpret the terms of the plan. This authority, as interpreted by the Supreme Court in

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Section 406 to make illegal *per se* transactions that may have a high potential for abuse).

15. See COLLEEN E. MEDILL, INTRODUCTION TO EMPLOYEE BENEFITS LAW: POLICY AND PRACTICE, 530 (2004); EMPLOYEE BENEFIT LAW, *supra* Appendix B note 14, at 702-05.

16. 29 U.S.C. § 1104(a)(1)(D) (2000).

17. See MEDILL, *supra* Appendix B note 15, at 417-18.

*Firestone Tire & Rubber Co. v. Bruch*,<sup>18</sup> is derived from the historical fiduciary power of the trustee of a trust to interpret the terms of the trust.<sup>19</sup>

In the everyday world of plan administration, fiduciaries are routinely called upon to interpret the terms of the plan and determine a participant's eligibility for plan benefits. As *Firestone* makes clear, interpretation of the terms of the plan is a task that is inherently fiduciary in nature.<sup>20</sup> Thus, a Group 5 claim for a violation of plan terms (failing to pay for benefits authorized by the terms of the plan) and a breach of fiduciary duty claim (for failure to follow the terms of the plan, which authorizes the benefits to be paid) are inherently intertwined.

In *Varity Corporation v. Howe*,<sup>21</sup> the Supreme Court implicitly acknowledged that a claim for wrongfully denied benefits under Section 502(a)(1)(B)<sup>22</sup> is intertwined with a breach of fiduciary duty claim under Section 502(a)(3). The Supreme Court in *Varity* did not reject the premise that a *claim* to enforce the terms of the plan entitling the participant to benefits under Section 502(a)(1)(B) potentially co-exists with a claim for breach of fiduciary duty under Section 502(a)(3) based on the fiduciary's failure to follow the terms of the plan.<sup>23</sup> Rather, the *Varity* Court stated that "normally" the *remedy* for a wrongfully denied claim for plan benefits would be limited to the remedy available under Section 502(a)(1)(B).<sup>24</sup>

My initial objective was merely to identify and clarify the various types of intertwined fiduciary claims. In the third order analysis stage of the modeling exercise, I determined that wrongfully denied claims for plan benefits were eligible for additional relief under Section 502(a)(3).<sup>25</sup> In Part III.D.3.d of the Article, I proposed a solution for how the federal courts should resolve the question of when an additional remedy under Section 502(a)(3) is "appropriate" for injury caused by a plan administrator's wrongful denial of plan benefits.

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18. 489 U.S. 101 (1989).

19. *See id.* at 110-11 (discussing applicability of trust law to ERISA plans).

20. *See id.* at 113-15 (discussing role of a fiduciary in ERISA plans).

21. 516 U.S. 489 (1996).

22. 29 U.S.C. § 1132 (a)(1)(B) (2000).

23. *See Varity*, 516 U.S. at 515.

24. *See id.*

25. *See discussion supra* Article Part III.C.2.a.

## APPENDIX C

CONSOLIDATION OF PLAINTIFF-DEFENDANT-CLAIM  
COMBINATIONS

<b>Combination (Plaintiff v. Defendant - Claim)</b>	<b>Consolidation Procedure Used</b>
1. Participant v. Employee Benefit Plan - Plan Design Requirements  2. Fiduciary v. Employee Benefit Plan - Plan Design Requirements	1. Consolidated with #2. (common defendant/common claim)  2. Consolidated with #1. (common defendant/common claim)
3. Participant v. Employer - Plan Design Requirements  4. Fiduciary v. Employer - Plan Design Requirements	3. Not possible due to settler function doctrine.  4. Not possible due to settlor function doctrine.
5. Participant v. Fiduciary - Plan Design Requirements  6. Fiduciary v. Fiduciary - Plan Design Requirements	5. Not possible due to settlor function doctrine. <sup>1</sup>  6. Not possible due to settlor function doctrine. <sup>2</sup>
7. Participant v. Participant - Plan Design Requirements	7. Not possible due to settlor function doctrine.

1. A fiduciary who administers an illegal plan term is subject to a breach of fiduciary duty claim.

2. See *supra* Appendix C note 16.

8. Fiduciary v. Participant - Plan Design Requirements	8. Not possible due to settlor function doctrine.
9. Participant v. Party In Interest - Plan Design Requirements	9. Impossible.
10. Fiduciary v. Party In Interest - Plan Design Requirements	10. Impossible.
11. Participant v. Third Party - Plan Design Requirements	11. Impossible.
12. Fiduciary v. Third Party - Plan Design Requirements	12. Impossible.
13. Participant v. Employee Benefit Plan - Retaliation, Improper Amendment Procedure, or Inurement	13. Impossible.
14. Fiduciary v. Employee Benefit Plan - Retaliation, Improper Amendment Procedure, or Inurement	14. Impossible.
15. Participant v. Employer - Retaliation, Improper Amendment Procedure, or Inurement	15. Consolidated with #16. (common defendant/ common claim)
16. Fiduciary v. Employer - Retaliation, Improper Amendment Procedure, or Inurement	16. Consolidated with #15. (common defendant/ common claim)

17. Participant v. Fiduciary - Retaliation, Improper Amendment Procedure, or Inurement	17. Not possible due to settlor function doctrine. <sup>3</sup>
18. Fiduciary v. Fiduciary - Retaliation, Improper Amendment Procedure, or Inurement	18. Not possible due to settlor function doctrine. <sup>4</sup>
19. Participant v. Participant - Retaliation, Improper Amendment Procedure, or Inurement	19. Impossible.
20. Fiduciary v. Participant - Retaliation, Improper Amendment Procedure, or Inurement	20. Impossible.
21. Participant v. Party In Interest Retaliation, Improper Amendment Procedure, or Inurement	21. Impossible.
22. Fiduciary v. Party In Interest - Retaliation, Improper Amendment Procedure, or Inurement	22. Impossible.
23. Participant v. Third Party - Retaliation, Improper Amendment Procedure, or Inurement	23. Impossible
24. Fiduciary v. Third Party - Retaliation, Improper Amendment Procedure, or Inurement	24. Impossible.

3. A fiduciary who *administers* the plan in violation of these statutory provisions is subject to a breach of fiduciary duty claim.

4. See *supra* Appendix C note 3.

25. Participant v. Employee Benefit Plan - Breach of Fiduciary Duties	25. Impossible.
26. Fiduciary v. Employee Benefit Plan - Breach of Fiduciary Duties	26. Impossible.
27. Participant v. Employer - Breach of Fiduciary Duties	27. Impossible.
28. Fiduciary v. Employer - Breach of Fiduciary Duties	28. Impossible.
31. Participant v. Participant - Breach of Fiduciary Duties	31. Impossible.
32. Fiduciary v. Participant - Breach of Fiduciary Duties	32. Impossible.
33. Participant v. Party In Interest - Breach of Fiduciary Duties	33. Combination is valid based on § 502(l) if party in interest knowingly participates in a fiduciary's breach. Consolidated with #34 due to common defendant/common claim, and with #45 and #46 based on § 502(l) as a common statutory source for the claim.

<p>34. Fiduciary v. Party In Interest - Breach of Fiduciary Duties</p>	<p>34. Combination is valid based on § 502(l) if party in interest knowingly participates in a fiduciary's breach. Consolidated with #33 due to common defendant/common claim, and with #45 and #46 based on § 502(l) as a common statutory source for the claim.</p>
<p>35. Participant v. Third Party - Breach of Fiduciary Duties</p> <p>36. Fiduciary v. Third Party - Breach Fiduciary Duties</p>	<p>35. Combination is valid based on § 502(l) if third party knowingly participates in a fiduciary's breach. Consolidated with #36 due to common defendant/common claim, and with # 47 and #48 based on § 502(l) as a common statutory source for the claim.</p> <p>36. Combination is valid based on § 502(l) if third party knowingly participates in a fiduciary's breach. Consolidated with #35 due to common defendant/common claim, and with # 47 and #48 based on § 502(l) as a common statutory source for the claim.</p>
<p>37. Participant v. Employee Benefit Plan - Prohibited Transaction</p> <p>38. Fiduciary v. Employee Benefit Plan - Prohibited Transaction</p>	<p>37. Impossible.</p> <p>38. Impossible.</p>



<p>39. Participant v. Employer - Prohibited Transaction</p> <p>40. Fiduciary v. Employer - Prohibited Transaction</p>	<p>39. The defendant employer could be sued for a prohibited transaction in its capacity as a party in interest.</p> <p>40. The defendant employer could be sued for a prohibited transaction in its capacity as a party in interest.</p>
<p>41. Participant v. Fiduciary - Prohibited Transaction</p> <p>42. Fiduciary v. Fiduciary - Prohibited Transaction</p>	<p>41. Consolidated with #42 due to common defendant/ common claim, and with #29 and #30 based on the common statutory source of fiduciary responsibilities under part 4 of title I of ERISA.</p> <p>42. Consolidated with #41 due to common defendant/ common claim, and with #29 and #30 based on the common statutory source of fiduciary responsibilities under part 4 of title I of ERISA.</p>
<p>43. Participant v. Participant - Prohibited Transaction</p>	<p>43. The defendant participant who is also an employee of the employer who sponsors the plan is a party in interest, see 29 U.S.C. § 1002(14)(H), and could be sued for a prohibited transaction in his or her capacity as a party in interest.</p>

<p>44. Fiduciary v. Participant - Prohibited Transaction</p>	<p>44. The defendant participant who is also an employee of the employer who sponsors the plan is a party in interest, see 29 U.S.C. § 1002(14)(H), and could be sued for a prohibited transaction in his or her capacity as a party in interest.</p>
<p>45. Participant v. Party In Interest - Prohibited Transaction</p> <p>46. Fiduciary v. Party In Interest - Prohibited Transaction</p>	<p>45. Combination is valid based on § 502(l) if party in interest knowingly participates in the prohibited transaction. Consolidated with #46 due to common defendant/ common claim, and with #33 and #34 based on § 502(l) as a common statutory source.</p> <p>46. Combination is valid based on § 502(l) if party in interest knowingly participates in the prohibited transaction. Consolidated with #45 due to common defendant /common claim, and with #33 and #34 based on § 502(l) as a common statutory source.</p>
<p>47. Participant v. Third Party - Prohibited Transaction</p>	<p>47. Combination is valid based on § 502(l) if third party knowingly participates in prohibited transaction. Consolidated with #48 due to common defendant /common claim, and with #35 and #36, based on § 502(l) as a common statutory source.</p>

<p>48. Fiduciary v. Third Party - Prohibited Transaction</p>	<p>48. Combination is valid based on § 502(l) if third party knowingly participates in prohibited transaction. Consolidated with #47 due to common defendant /common claim, and with #35 and #36, based on § 502(l) as a common statutory source.</p>
<p>49. Participant v. Employee Benefit Plan – Violation/Enforcement of Plan Terms</p> <p>50. Fiduciary v. Employee Benefit Plan - Violation/ Enforcement of Plan Terms</p>	<p>49. Impossible. The appropriate defendant here would be the plan administrator charged with administering the terms of the plan.</p> <p>50. Impossible. The appropriate defendant here would be the plan administrator charged with administering the terms of the plan.</p>
<p>51. Participant v. Employer - Violation/Enforcement of Plan Terms</p>	<p>51. Action by the employer that is contrary to the terms of the plan would result in an exercise of administrative or managerial authority over the plan and thereby render the employer a defacto fiduciary with respect to such action. The defendant employer could be sued in its capacity as a defacto fiduciary for a breach of fiduciary duty (failure to follow plan terms).</p>

<p>52. Fiduciary v. Employer - Violation/Enforcement of Plan Terms</p>	<p>52. Action by the employer that is contrary to the terms of the plan would result in an exercise of administrative or managerial authority over the plan and thereby render the employer a defacto fiduciary with respect to such action. The defendant employer could be sued in its capacity as a defacto fiduciary for a breach of fiduciary duty (failure to follow plan terms).</p>
<p>53. Participant v. Fiduciary - Violation/Enforcement of Plan Terms</p> <p>54. Fiduciary v. Fiduciary - Violation/Enforcement of Plan Terms</p>	<p>53. Consolidated with #54 due to common defendant/ common claim, and with #29 and #30 based on a common statutory source (§ 404(a)(1)(D)) for a breach of fiduciary duty claim.</p> <p>54. Consolidated with #53 due to common defendant/ common claim, and with #29 and #30 based on a common statutory source (§ 404(a)(1)(D)) for a breach of fiduciary duty claim.</p>
<p>55. Participant v. Participant Violation/Enforcement of Plan Terms</p> <p>56. Fiduciary v. Participant Violation/Enforcement of Plan Terms</p>	<p>55. Consolidated with #56. (common defendant/ common claim)</p> <p>56. Consolidated with #55. (common defendant/ common claim)</p>

<p>57. Participant v. Party In Interest Violation/Enforcement of Plan Terms</p> <p>58. Fiduciary v. Party In Interest Violation/ Enforcement of Plan Terms</p>	<p>57. Consolidated with #58 due to common defendant/ common claim. If a party in interest knowingly participates in a fiduciary's violation of plan terms (a breach of duty by the fiduciary) the claim is consolidated with #33 and #34. If party in interest knowingly participates in a violation of plan terms by a participant, the claim is consolidated with #59 and #60<sup>5</sup>. See Article Part II.C.3.f for discussion of validity of this claim.</p> <p>58. Consolidated with #57 due to common defendant/ common claim. If a party in interest knowingly participates in a fiduciary's violation of plan terms (a breach of duty by the fiduciary) the claim is consolidated with #33 and #34. If party in interest knowingly participates in a violation of plan terms by a participant, the claim is consolidated with #59 and #60.<sup>6</sup> See Article Part II.C.3.f for discussion of validity of this claim.</p>
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5. If the claim is based solely on a violation of plan terms that does not involve a breach of duty by a fiduciary, the claim is outside the scope of § 502(l). For purposes of analysis, the status of the defendant as a party in interest in this situation is indistinguishable from a third party who participates in a nonfiduciary's violation of plan terms.

6. See discussion *supra* Appendix C note 5.

<p>59. Participant v. Third Party - Violation/Enforcement of Plan Terms</p>	<p>59. Consolidated with #60 due to common defendant/common claim. If a third party knowingly participates in a fiduciary's violation of plan terms (a breach of duty by the fiduciary) the claim is consolidated with #33 and #34. If a third party knowingly participates in a violation of plan terms by a participant the claim is consolidated with #57 and #58. See Article Part II.C.3.f for discussion of the validity of this claim.</p>
<p>60. Fiduciary v. Third Party - Violation/Enforcement of Plan Terms</p>	<p>60. Consolidated with #59 due to common defendant/common claim. If a third party knowingly participates in a fiduciary's violation of plan terms (a breach of duty by the fiduciary) the claim is consolidated with #33 and #34. If a third party knowingly participates in a violation of plan terms by a participant the claim is consolidated with #57 and #58. See Article Part II.C.3.f for discussion of the validity of this claim.</p>